



Researching Quality Systems and Developing Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland

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Researching Quality Systems and Developing Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland



January 2013

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Executive Summary:

1. Introduction:

This report presents the findings of research commissioned by the Irish Association of Suicidology to produce an accreditation model for voluntary organisations working in the field of suicide prevention, intervention and postvention in Ireland. The research was funded by Department of Health through the National Office of Suicide Prevention. The research was conducted by the Community Youth Work Department of the School of Sociology and Applied Social Studies at the University of Ulster. The research commenced in **May 2012** and concluded in **December 2012**.

2. Research Objective:

To develop a model for the accreditation and review of the work of voluntary organisations working in the suicide prevention, intervention and postvention sector in Ireland and to support best practice and good governance in service delivery.

3. Methodology

The study made use of a mixed method of data collection including quantitative and qualitative methods. The national and international literature into the accredited practices and processes of reputable organisations regionally, nationally and internationally was reviewed. Voluntary organisations were invited to complete an online survey and semi structured interviews were held with a representative sample of national, regional and local organisations from the suicide Prevention, Intervention and Postvention sector.

The data was complimented by the addition of a review of interim findings by expert groups in October 2012.

A total of 60 organisations were invited to participate in the research process. They were requested to submit a return email as a record of organisation consent as required by University of Ulster ethical procedures. Of the 60 organisations invited a total of 46 organisations responded and submitted informed consent. These organisations were forwarded a questionnaire. By September 2012, 26 of the 60 groups originally invited to participate had completed the questionnaire.

The second phase of the research involved semi-structured interview with 30 identified organisations national (N=10), regional (N=10) and local (N=10). Interviews were carried out and completed with 27 organisations and where required phone meetings and email correspondence occurred when physical meetings proved difficult to arrange due to a variety of reasons such as annual leave or ill health.

4. Key Findings and Recommendations:

The depth and breadth of the findings can be accessed within the main body of the report. This executive summary outlines salient themes and findings drawn from the quantitative data and the qualitative interviews held with participating national, regional and local organisations.

It is evident that an effective evaluation and accreditation model can be devised but the authors are clear that in developing such a model we must take account of the “process” for organisations and individuals within them. It is important to develop a strategy that considers and ensures minimum adverse impact on staff, one which ensures skills and confidence for those managing change within organisations, generates a high level of involvement from the suicide prevention sector and that effective communication takes place.

The research indicates that a majority of organisations working in the sector view their services as concentrated in the area of Mental Health promotion and well-being.

Promotion and marketing of suicide prevention, intervention and postvention services by organisations requires expertise, resources and skills. In particular, smaller groups indicate difficulty in developing effective marketing and advertising resources. Services on offer are advertised and promoted using a range of methods and strategies including printed media, leaflets and newspapers, radio, Facebook and social networking, websites and other methods as defined by respondents

The data indicates that web based and new technologies with printed materials form the greatest percentage of resources. The relationship between the organisations and local print media and local radio has proved to be a valuable resource to smaller local and community groups who seek to improve awareness

Ninety two per cent of respondents require a minimum qualification with the lowest level an undergraduate diploma with respondents stating that a range of qualifications inclusive of degree, post graduate and masters level being found acceptable to organisations.

Professional accreditation appears to be a universal requirement with a number of accrediting bodies being deemed acceptable for practice.

Garda /PSNI clearance, from the author's perspective should be a nominal prerequisite for all organisations and practitioners in this field as findings indicate not all volunteers are subject to garda/police clearance within the sector.

Responses indicate that all organisations make use of volunteers but in some cases organisations appear to rely more heavily upon small numbers of full or part time employees (on average less than five) with volunteers carrying out many of the core duties. The majority of groups (56%) make use of paid or voluntary counsellors in their provision of services.

5. Guiding Principles: Ethos and Values

The model offers a number of guiding principles that are recommended for all organisations engaging in the accreditation process. Such principles must actively consider the overall ethos and vision of the organisation, its code of ethics and practice that includes an understanding of good boundaries and self care. Essential to such a consideration is that it be actively informed by the rights and responsibilities to and for the client within a person centred approach to pre/post and intervention practices.

The recommended model of accreditation has a foundation level of essential governance and structure which must be adhered to for all organisations.

5.1 Qualifications

The accreditation model recommends a level of minimum qualification suitable to basic practice and interventions carried out by staff or volunteers.

5.2 Inspection

The accreditation model will consider and recommend an inspection procedure.

5.3 Training and Development

The model of accreditation contains elements that address training and development as prerequisites to practice.

5.4 Collaboration and Strategic Planning:

The model of accreditation contains elements that address the requirement for a collaborative and partnership approach to working which considers cross sector, thematic and geographic collaborative approaches.

5.5 Funding and Accreditation

The implementation and management of the accreditation model may wish to examine a direct relationship between funding for organisations and engagement with the accreditation process.

5.6 Managing and Marketing Accreditation

The model of accreditation requires an implementation and marketing strategy to support and encourage engagement by organisations at national, regional and local level and across organisation in the statutory/voluntary sector who are involved in suicide prevention, intervention and postvention.

5.7 Communication

The research recommends the development of a communication strategy to support the suicide prevention, intervention and postvention sector. Such a communication strategy must be linked to strategic planning and collaboration policies of organisations.

5.8 Information Management and Data Collection/ Resources

It is recommended that resourcing toward the development and implementation of accreditation must be addressed to support and sustain the suicide prevention, intervention and postvention voluntary sector.

6. Introduction to the Model:

It is essential in developing any model of accreditation that it is formed around the highest guiding principles and values that should inform and determine the direction and emphasis of the model. Such principles and values must be at all times in a process of considered development and rooted in a shared ethical base of reflection and practice. Such values and principles must be open to an on-going process of being developed and shaped by the experiences and feedback of staff and service users they should be considered as an open ended and vital practice to any engagement by those working in the field of suicide prevention, intervention and postvention.

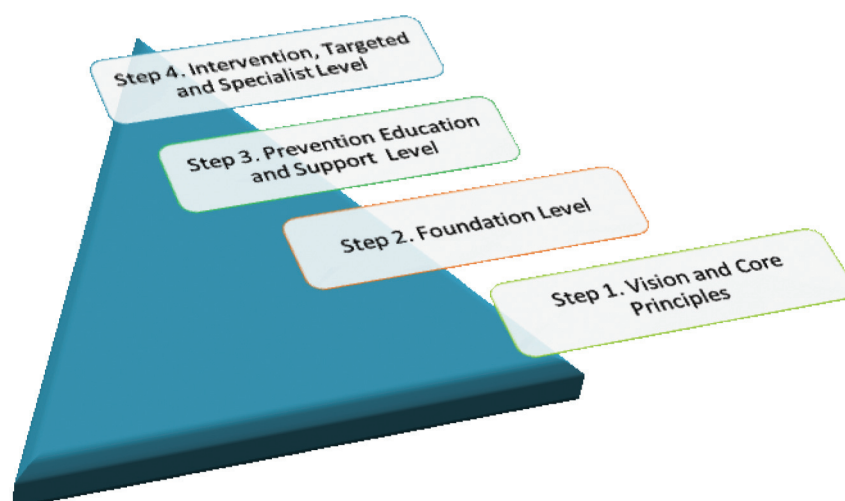
There is a need for fundamental guiding principles that permit and facilitate openness, transparency, collaboration and partnership nationally, regionally and locally.

STEP: Model of Accreditation for the Voluntary Suicide Prevention, Intervention and Postvention Sector in Ireland.

The STEP model of accreditation is based upon the quantitative and qualitative research findings, examination of international and national literature on accreditation models and exploration of existing models across a number of sectors and professional disciplines. The aim is to ensure that the model recommended for use in the suicide prevention, intervention and postvention sector has clarity of purpose, succinctly captures pertinent and important themes, uses clear language and can be engaged with at a number of levels.

The STEP Model

The model of accreditation is developed as a layered and “stepped” approach with a foundation level and increasing levels of accreditation linked to the practice of organisations. The model is outlined below:



The accreditation requirements at each step are outlined within the document.

Each item contained in the STEP Model of accreditation is written as a statement of action or behaviour (e.g. “the organisation has a strategic plan”). Organisations will identify at which step they operate and will clarify the services of the organisation against the matrix of statements of good practice”

STEP1. Vision Purpose and Core Principles

The initial stage of engagement with the STEP model of accreditation supports organisations to clarify and review the organisation vision, purpose principles and values. This should inform and determine the direction and emphasis of the organisations requirements within the STEP model.

STEP 2: Foundation Level

Following the review of literature and examination of a variety of models and standards of accreditation; and having completed the research with organisations, it is agreed that the first stage of the accreditation process will be completed by all organisations and will involve a set of accreditation themes covering key indicators with the associated elements.

STEP 3: Prevention, Education and Support Level

The STEP model seeks to ensure that through good governance and effective management at a foundation and universal level that organisations are best placed to deliver coordinated practices and services of consistently high quality, with education a particular and important aspect to overall provision within the sphere of suicide Prevention, Intervention and Postvention practice. Coupled with this any information transmitted must also be delivered within a clear and concise framework and in a practical and understandable language and manner.

The organisation is accountable to ensure effective governance around the responsible, considered practice and strategy in the development of effective services.

In addition to the Foundation Level, Step 3 comprises core activities that organisations undertake. These activities involve Prevention, Education and Support and a number of distinct indicators, listed below will assist organisations to ensure required standards of practice.

Step Four: Intervention, Targeted and Specialist Level

The STEP model aims to ensure that through good governance and effective management at a foundation level that organisations are best placed to deliver coordinated practices and services of consistently high quality within the sphere of suicide Prevention, Intervention and Postvention practice. Coupled with this any information transmitted must also be delivered within a clear and concise framework and in a practical and understandable language and manner.

In addition to the Foundation Level, Step 4 comprises core activities that organisations undertake. These activities involve intervention, targeted and specialist services and a number of distinct indicators will assist organisations to ensure required standards of practice.

Conclusion:

This research has found that the voluntary organisations working within the areas of deliberate self-harm, suicide Prevention, Intervention and Postvention in Ireland are a vibrant, committed, important and essential component of any national strategy to address this difficult, complex and painful issue for families and communities.

This study used a mixed and creative approach to understanding and developing a model of accreditation. It was informed at all times by the work and experience of those local, regional and national organisations that engaged in and fully informed the research. This is the model realised from their vision and experience.

In the incoming months the model, informed by this consultation, will be fully implemented within the suicide prevention, intervention and postvention sector in Ireland. Even this conclusion is not the final word on the work carried out as this model will be reviewed and developed over the next few years.

Acknowledgements

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Introduction

Suicide is most often the result of pain, hopelessness and despair. It is almost always preventable through caring, compassion, commitment and community.

Canadian Association for Suicide Prevention : 2nd Ed : 2009
L'association Canadienne pour la prévention du suicide

Introduction

In her introduction to the National Suicide Strategy for England the then Minister Jacqui Smith observed, *"Suicide is a devastating event. Its emotional and practical consequences are felt by family and friends and the many statutory and voluntary agencies involved in the provision of health and social care"*.

Miss Smith went on to observe that whilst in real terms the rate of death by suicide in England had not reached the heights of some of their European partners suicide was the commonest form of death for men under thirty five years. It was the main cause of premature death in people with mental illness.

It is a surprising assertion, then, for the authors in the light of the above statement, to consider that, The Irish Association of Suicidology (IAS) estimates that, for an island of its geographical size, there may be approximately 300 or more organisations and community groups working in the area of suicide prevention in Ireland. (IAS Newsletter: 2011), Whilst it is acknowledged, that the actual number may be hard to calculate the IAS Newsletter observes: *"Whatever the size or structure of the group they all make an invaluable contribution to reducing the risk of suicide in Ireland"* (IAS: 2011)

The causes and factors are well documented but do bear repeating lest we become blasé in assuming our knowledge of cause and effect of death by suicide in Ireland. Factors include but are not exclusively social and environmental, the effect of differing abilities biological vulnerability and physical disability, mental and emotional health issues, major impact on lives by uninvited events, such as the loss of a loved one, social collapse, unemployment or lack of access to services that might impact positively upon ones frame of mind, mental and emotional health. Isolation and fear and shame as to how one might be perceived also have a major impact on those considering suicidal acts in a hidden environment of shame and possible misunderstanding.

Suicide in Ireland is a major health concern and has had a devastating impact on communities from the micro to the macro level, on individuals, families, groups and organisations. It has, as observed within the Canadian model, been borne in silence as much among the professionals involved in mental health and emotional well-being practices as among families and communities that have reverberated with the effects of death by the act of suicide. CASP; 2009:9

The authors earnestly concur with the authors of the Canadian report in their assertion that the time has come to have the courage to stand up to stigma, to confront that silence, to educate ourselves, to move into action and to reach out to comfort the suffering. CASP: 2009:9. To do so, it is important to offer some consideration to the central question can we prevent suicide and thus ensure that the pain and suffering felt by each individual that considers the act of suicide as a viable option be addressed and subsequently alleviated.

In striving to address the pertinent questions that coalesce around the issue and to eventually ensure a quality of practice and a coherent accreditation of standards we must ensure that we can positively impact and assist those organisations that battle across the areas of postvention, prevention and intervention to ensure that any that call upon their services finds the most effective practice that can be offered anywhere nationally or internationally.

There is a devastating truth that informs the authors and every practitioner. It is summed up succinctly in the National Strategy for England, *"that each suicide represents both an individual tragedy and a loss to society. Suicide can be devastating for families and other 'survivors' – economically, psychologically and spiritually"*.

With this statement in mind it is important to acknowledge that we all bear a responsibility to support and pursue actions of suicide prevention, postvention and intervention as an obligation and a duty to our communities and societies. In doing so we assert that we respect all peoples without equivocation, that we embrace the differences of culture, gender, preference race or religion without any sense of prejudice and judgement. Communities that embrace such an approach do so from a number of foundations, those of compassion, respect, openness and commitment. By facing down the stigma of suicide and suicidal behaviour we can, by all our efforts, seek to embrace the vulnerable and iso-

lated and humanely address the mental and emotional needs of all in our communities. The Canadian model reminds us that any approach must always come from the foundations of patience, respect and courage: CASP: 2009:9

For these and other pertinent reasons the issue of best practice and governance within the voluntary sector is a research priority for our consideration. The authors aim in developing, in partnership with all who contribute to the research, a set of draft accreditation standards that will, in the last analysis help all organisations and practitioners to create a real reduction of death by and through the act of suicide and reduction in deliberate self-harm in Ireland.

The authors, in line with the agreed structure, have considered a number of national and international strategies and models of accreditation including those drawn from Australia, Canada, the United States of America, The Republic and Northern Ireland, Great Britain and India. These have informed both the research as a whole and also informed areas necessary and pertinent to any consideration of an accreditation model pertaining to Ireland. Consequently these models are emphasised throughout the research with the best and most effective of these phases of accreditation identified and presented for active consideration as those that will best suit and ensure best practice within an Irish draft model of accreditation for organisations involved in Prevention, Intervention and Postvention organisations addressing suicide and suicidal ideation in Ireland.

Further to this the authors considered structures and documents as disparate and diverse as The Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland, The PQASSO model, Quality Standards for Youth Work Practice, Fit for Purpose guidelines, RAMP Guidelines for use of web based technologies in Mental Health Provision, Australian Mental health Standards (2010) and The Clear model Of Intervention from Northern Ireland. On from this and incorporated through our deliberations we also drew elements from the quality standards for youth work practice, The National Strategy For Suicide prevention and The American Association Accreditation 10th Edition and the Good Samaritan, Volunteers and Volunteer organisations Act (2011).

These are detailed, well documented and considered models of quality assurance. In the main they share a number of considerations including;

- Rights and responsibilities
- Promotion and implementation of training to recognise at risk behaviour and to identify appropriate response and treatment.
- Ensuring a functioning and sustainable programme of operations maintained and carried out and through partnerships across statutory, voluntary and community led initiatives.
- Safety
- Consumer and carer participation
- Diversity responsiveness
- Promotion and prevention
- Consumers
- Carers
- Governance, leadership and management
- Integration
- Delivery of care
- Supporting recovery
- Access
- Entry
- Assessment and review
- Treatment and support
- Exit and re-entry

Added to this is the primacy of place given to the uniqueness of the person, their human rights protection, their access to authentic programmes and personal choice incorporating dignity, respect, partnership and non-judgement in practice and reality. Any model of intervention must be generically incorporative of the above and other considerations and elements and must lead to a comprehensive, nationally integrative approach to suicide Pre/Post and Intervention practices. Such a model influences the development of partnerships and practices. It engages all at a level of equity whilst recognising the diversity of approach to the situation in hand.

The considered models are built upon identified need and experience of service. They are layered, phased or tiered. Some are general models, some catch all, some are such as to permit entry into the Accreditation model based upon practice level, whether, local community, regional or national. There is a very real need for any model to consider uniqueness of approach and impact, to ensure that this is enshrined and seamed through the model, informing its development and purpose.

In setting out upon this research the authors are acutely aware of the burden of responsibility that they and those who contribute to this research and the consequent draft accreditation standards that will emanate from its findings have to the families, communities and societies already adversely affected by acts of suicide and those who live in fear of it occurring to them and their families.

1: Suicide and Deliberate Self-Harm Defined

The definition of suicide in Ireland is contained in Reach Out, the national strategy and is stated as *"A conscious or deliberate act that ends one's life when an individual is attempting to solve a problem that is perceived as unsolvable by any other means"* (Commonwealth Department of Health and Aged Care, Life Strategy, (Australia; 1999): Suicide, as defined by Durkheim, cited in Pope (1982:110) is determined as, *"all cases of death resulting directly or indirectly from a positive or negative act of the victim, which he knows will produce this result"*. Over recent decades, death by suicide has greatly increased. In the island of Ireland this has led to Central Statistics Office data for 2011, revealing that the number of suicides registered in Ireland rose to 525 in 2011, an increase of seven per cent on the previous year. According to the data a total of 439 men and 86 women were recorded as having taken their own lives, the majority of whom were aged 15-44. This is a decrease of only two on the record high in 2009 of 527 suicides.

Suicide is, of course not a new issue but it is important to note the uncomfortable truths leading to the marginalisation of those at risk and our general difficulty and fear of dealing with vulnerable clients directly. Reeves, in a 2004 article, argues that those working therapeutically with suicidal clients are impacted by feelings of incompetence, guilt, anger, anxiety and a sense of professional incompetence. (Therapy Today 2004:26) In 1996 the Department of health and Social Services and Public Safety (DHSSPS)(NI) argued that an approach that encouraged all interested parties to work alongside each other to develop a strategy, whilst only a beginning would by necessity need to, *"be accompanied by wider action to promote positive mental health"*.

Barbiker and Arnold, cited in Feltham, C. and Horton, I. (2012) define self-harm as *"an act which involves deliberately inflicting pain and/or injury to one's body, but without suicidal intent"* (1997). The National institute for Clinical Excellence (NICE) state that self-harm is *"self-poisoning or injury, irrespective of the apparent purpose of the act"* *"they also state that "self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself"* (2004) (ibid). The Barbiker and Arnold definition distinguishes between self-harm and suicidal ideation with their statement *"without suicidal intent"* and Reeves, A (ibid) states that *"self-harm is usually used as a coping strategy against profound or overwhelming feelings of distress"* (2012) (ibid.). A report by the Royal College of Psychiatrists in the UK in 2010 stated the acts of self-harm may not be an attempt or an indicator of suicide but may in fact be a *"bizarre form of self-preservation"* (2012) (ibid.). It is the assertion of the authors that acts of self-harm can be sufficiently serious and severe enough to place life at risk and it is a risk to life with or without intent. This research asserts that self-harm is correlated with an increased risk of suicide and thus risk assessment indicators are essential to good practice in the sector.

With this at the forefront of the mind the authors accept that the task of developing and introducing any proposed or accepted series of accreditation standards for voluntary suicide prevention organisations in Ireland, is not undertaken lightly nor is the task of such a proposed development underestimated by the authors. Consequently, serious consideration of models of accreditation in place both nationally and internationally has informed this review. The purpose of this approach is to ensure that there has been extensive and coherent consideration as to how those quality assurance and accreditation models may determine or inform the development of standards for Ireland. The author is confident that such an approach can best serve to inform our own level of understanding of the quality assurance and accreditation models offered by and through these models already in place in other countries.

To ensure a responsible approach to this review the author followed a set of guidelines in order to ensure appropriate current thinking and practice was represented within the following pages.

1. To review national and international literature on accreditation models and quality systems. This review occurs through the model of desk research including intensive study, reading and drawing together of relevant recent and current approaches, models and background information into the accredited practices and processes of reputable organisations regionally, nationally and internationally and will inform the development of any emergent development of standards emanating from this research.
2. The authors utilised all reputable methods of information gathering inclusive of database searches including the use of the World Wide Web in identifying models of practice and accreditation in major centres of population and practice. Coupled with this and in line with accepted research methods the authors sought to ensure cognizance of accepted and reputable sources of relevant information that was inclusive of web sites of recognised, practising health and social care programmes both national and international.
3. In order to inform the development of accreditation standards that are realistic grounded in good practice and effective thus supporting organisations to inform best practice and procedures in working with the service users, communities and clients, the authors have strenuously sought to ensure that all literature and information reviewed and considered is up to date and takes in the practices current within the United Kingdom, Ireland North and South, Mainland Europe,

Australia, Canada and the United States of America.

As observed by Millar et al 2001, a logic model, is a tool, used effectively for almost a quarter of a century by managers and evaluators, to express the effective nature of their practices and programmes. This process takes as its starting point the required inputs then subsequently moves forward reflecting a tendency toward the limiting of ones thinking to existing programmes activities and research questions. Millar argues for an inversion of this approach thereby concentrating on the outcomes we seek to achieve.

Paul McCawley, of the University of Idaho, in reflecting this thinking in his article The Logic Model, suggests the following sequence of questions, which the author contends speak logically to the consideration of this current research. In our remit to ultimately develop a set of accreditation standards it is timely to consider the following questions as adapted from McCawley article to inform the remit of the research:

1. *What is the current situation that we intend to impact?*
2. *What will it look like when we achieve the desired situation/outcome?*
3. *What behaviours/practice needs to change for that outcome to achieve?*
4. *What knowledge or skills do people need before the behaviour/practice will change?*
5. *What activities need to be performed to cause necessary learning?*
6. *What resources will be required to achieve the desired outcome?*

As will become clear within the methodology section of this research the authors utilised an initial quantitative survey which was distributed to sixty organisations nationally, regionally and locally across the island of Ireland. Such a practice elicited material pertinent to the governance and practice of the various organisations and offered the authors the opportunity to identify similar and different themes shared by the participant organisations thus indicating possible implications for the development of accreditation models pertinent to the experience and practice of the organisations.

Further to this the authors concurred in the belief that the place of the semi structured interview was beneficial and indeed pivotal to this particular piece of research. Consequently the authors interviewed thirty identified organisations, (10 national, 10 regional and 10 local) to conduct, review and evaluate current practices and procedures. This offered an opportunity to effectively connect all the issues at an abstract and actual level for the deeper and broader purpose of developing an authentic understanding of the issues. It will also help to identify practices engaged in and by the participant organisations and from this to move toward the overall product of a set of accreditation standards for voluntary suicide prevention organisations in Ireland.

The use of this linear model within the research permits the unfolding of a multi-dimensional process of development with, as McCawley observes, *"The output from one effort becomes the input for the next effort"*.

All of the above, the authors suggest, are legitimate considerations that will assist in our process of evolution in determining the accreditation standards for those working in the area of suicide prevention in Ireland.

2: Research Context

"But from this wound which never quite heals, flow their amazing power to work."

Willibrand Lauck.

Charles Handy stated in 1992 *"In three to four years time, half as many people will be paid twice as much for working three times as hard"*. The context for the community and voluntary suicide prevention, intervention and postvention sector in Ireland is fraught with increasing difficulties arising from an ever changing landscape of political, economic and social change. These changes have resulted in funding difficulties, a high level of competition for, and demand for value for money, for the limited resources targeted to support the valuable work of the voluntary sector. The past number of years has marked a shift in accountability in all sectors, much is questioned and there is a demand for transparency in the development, practice and delivery of services. The development of the "what works model" and evidenced based practice has changed expectations of agencies and as Breakwell (1995) states:

"Evaluation techniques are essential tools of management practice today. No professional can afford not to take an analytic approach to the job to be done. Evaluation is the first step towards improving your own performance and the performance of others – the precursor to maximizing effectiveness, the mechanism for minimizing ineffectiveness"

3. Literature Review

3:1. Accreditation: A brief history

*"No Task is so difficult, to set about, No Leadership so delicate, No venture so hazardous
As the attempt to introduce a new order of things"*

Machiavelli 16 c

Accreditation would appear to have its foundational basis in the United States of America around the period of 1913. At that point in its history the American College of Surgeons asserted that, *'those institutions having the highest ideals may have proper recognition before the profession.'* (Roberts 1987). In transferring their standardisation programme to the JCAH, The Joint Commission on Accreditation of Hospitals the same body that in 1953 published Standards for Hospital Accreditation. These standards, as observed by Sale (2005), are linked to funding and the hospital accreditation programmes demand evidence that a hospital has systems of quality assurance.

By 1979 the Netherlands had created their own systems for accreditation for organisations working in suicide prevention, with New Zealand following suit in 1987 as indeed did its nearest neighbour, Australia. Sale (2005). It would not be until 1989 that Ireland's nearest geographical neighbour would institute a steering committee to consider and take a critical view of existing standards and the monitoring of national standards when the Kings Fund Centre established the aforementioned body. It gave principle consideration to the models of the United States of America, Australia and Canada settling upon the Australian model as the most advantageous and appropriate. In Ireland discussion had been taking place during this period within the IAS, and between the IAS and other statutory and voluntary providers about the development of an accreditation model in this country. Dr John Connolly (IAS) had consulted with American Association of Suicidology (AAS) and discussed such a development with the National Office for Suicide Prevention as early as 2005.

The Kings Fund Organisational Audit led to the development of national standards for acute hospitals. The Audit was rebranded in 1998 as The Health Quality Service, gaining accreditation from the UK Accreditation Service. Cited in Sale (2005).

3:2. Accreditation - an unfolding text.

In setting out the authors considered it of prime importance to agree upon working criteria to permit a logical development and progression. Having considered various models the NHS Model of Accreditation analysis presented as an easy to follow guide and is adapted presented for consideration.

- **Scope and purpose**
 - Overall objective
 - Clinical, healthcare/social questions covered
 - population and /or target audience to whom the guidance will apply
 - Guidance to include clear recommendations in reference to specific clinical, healthcare or social circumstances.
- **Stakeholder involvement**
 - Organisations from relevant groups in developing guidelines
- **Rigour of development**
 - Requires the systematic methods to search for evidence and provide details of the search strategy.
 - Requires the stating of criteria and reasons for inclusion and exclusion of evidence identified by review.
 - Describe the strengths and limitations of the body of evidence and acknowledges any areas of uncertainty.
 - Describe the method used to arrive at recommendations.
 - Requires the consideration of health benefits against the risks in formulating recommendations.
- **Clarity and presentation:**
 - Recommendations are specific unambiguous and clearly identifiable.
 - Options for the management of the situation or options for intervention are clearly presented.

The authors considered accreditation models and frameworks coupled with elements of various models that included the standard development processes and the criteria central to the systems. From this it proved necessary to consider underpinning principles that permit the development of standards, practice and governance models.

3:3. Accreditation: A model for considered practice

"It is difficult to evaluate or determine the benefits that accreditation can bring to an organisation because the 'end points or products' of accreditation are hard to define. They vary according to the experience of users and observers, the starting point of the organisation and the rigour of the accreditation process."

(Australian Commission for Safety and Quality in Healthcare 2006)

Any attempt at accreditation carries with it the duty to ensure that any practices undertaken within and throughout organisations working within the sector are carried out and guided by the desire to ensure an unfolding text of quality improvement within their services and processes. Consequently any model of accreditation should, as suggested by the Australian Mental Health Guidelines of 2010, focus upon a number of pertinent factors and considerations.

- How services are delivered.
- Whether they comply with policy direction.
- Whether they meet expected standards of communication and consent.

In developing standards the Australian experience observes that the development of any model must be applicable across the breadth and range of practice and should be founded upon the consideration as to whether organisations currently have, *“processes and practices in place to monitor and govern particular areas especially those which may be associated with risk to the consumer”*. In considering the development of a possible model of accreditation, it is timely to acknowledge, as posited by the Authors of the foreword to the Australian report of 2010 that, *“while accreditation is one measurement to monitor compliance, it is by no means the only one”*. As this report rightly goes on to observe other frameworks including those of performance indicators and licensing process may also offer valuable evaluative properties. (Australian Model: 2010)

In considering our approach to this research, the authors felt an incumbent responsibility In the light of the Australian experience to ensure that should an accreditation model present itself from the deliberations of our efforts we must ensure that at its heart lies the very real obligation of ensuring that it offers real direction and improvement to any services or organisations that engage with such a model to measure and evaluate their processes and projects. (Australia 2010)

3:4. Typical stages in an accreditation process

There are what we may term typical stages to be considered in the development of any accreditation process. These must be critically underpinned by a number of considered principles. Any developed model of accreditation considered or implemented by other national or international bodies of governance and quality have been informed by such principles. Whilst they may place different emphasis on individual principles they uniformly agree that they lie at the heart of good governance and practice.

Such principles should be inclusive of a commitment to quality of service to the client and their families. Such services are delivered on the belief that they will have as their objective the ongoing recovery and support of those who seek out the programmes on offer. Further to this and in order to ensure that the model is organically informed and developed is that the client or service users have a pivotal place in any decision-making process or programme development. In taking such a participative approach the organisations ensure that the planning and delivery of their services is properly and effectively evaluated.

From this, consideration must be given to the following areas.

- Development of criteria and standards against which to compare the practices of individual organisations, voluntary bodies and programmes.
- Self-evaluation, based on the criteria, by the institution or programme.
- Preparation of organisation programme for on-going review.
- Site visit by peers to clarify, verify, and amplify what is reported in the self-study
- Site-visit report
- Board or panel reviews the evidence
- Establish mechanism for periodic review

Accreditation for voluntary organisations and groups working in the area of suicide prevention, intervention and postvention in Ireland has been discussed since the publication of the National Task Force Review Group on Suicide in 1998. Consultations had been on-going since that time between Dr John Connolly (IAS) and a number of stakeholders from the National Office of Suicide prevention and other organisations. The foundation of Reach Out a National Strategy for Action on Suicide Prevention 2005-2014 includes the guiding principles, outlined by Dr. John Connolly, as *“action focussed, practical, achievable, regular evaluation, broad based and evidence based”* (IAS Newsletter: 2011). In this regard the development of an accreditation process will support a more collaborative development of services nationally.

The Irish Association of Suicidology (IAS) believes that there is the opportunity for a “national Forum” (IAS Newsletter: 2011) which will facilitate regional networks and establish an accreditation model. Such a model will create improved response within the sector, offer boundaries, and structural supports for groups, staff, and volunteers. It will facilitate the distillation and sharing of knowledge skills, processes, and procedures within the area of suicide prevention, intervention, and postvention in Ireland.

Initial consultations were held with organisations throughout Ireland between March-May 2011. Meetings concluded that whilst such a model would be of benefit to the sector, it could not be imposed and should be developed and implemented by the sector. It is against such a backdrop that the IAS commissioned research which aimed to develop accreditation standards for voluntary suicide prevention organisations in Ireland.

3:5. Defining Accreditation

In seeking to define accreditation the authors considered a number of definitions as proposed by national and international bodies involved in the area of suicide prevention work. The American Association of Suicidology (2011) observes that “*The Accreditation process represents the American Association of Suicidology value system for crisis programmes, which the standards define and identify as objectively observable element of service*”, whereas the British Accreditation Council (2010) take the opinion that, “*Accreditation involves enabling an organisation to state publicly that it has voluntarily accepted independent inspection*”.

For those involved within the discipline of therapeutic intervention the British Association for Counselling and Psychotherapy (BACP) (2010) suggest that, “*Accreditation offers a framework for good practice*”.

For the purposes of this review the authors have settled upon Scrivens definition of accreditation as, ‘*a system of external peer review for determining compliance with a set of standards*’. Further to this, as observed by Sale 2005, accreditation involves a review of an organisations performance by an external body against measured and explicit standards and agreed criteria.

As postulated by the British Association for Counselling and Psychotherapy, accreditation processes are designed to ensure “good practice” (BACP: 2010) and is a “*voluntary quality assurance scheme*” (British Accreditation Council: 2010); this offers an opportunity for organisations, individuals, companies and educational institutions to indicate that their practice and procedure have undergone inspection. Accreditation offers an assurance of quality, standards, and professional development.

In any attempt to draw together effective accredited standards the above represents a signposting approach for those tasked with drawing them up and a simple and effective model to follow. This is true whether the model pertains to professional or voluntary practices within suicide prevention, postvention or intervention. For the purposes of this research the authors considered the definition offered by Dr. Paul Elliot’s *A Core Model for Professionally Led, Clinical Service Accreditation*, (2009) as relevant to the current research.

Elliot et al considered accreditation to be “*a self-assessment and external peer assessment process used by [clinical services] to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve*.”¹ This definition is consistent with the proposal that, although it does involve making a summative judgement about the quality of a service, the primary purpose of this form of accreditation is quality improvement; as opposed to assurance that minimum standards are met

3:6. An Underpinning of Effective accreditation

Elliot posits that in order to underpin effective accreditation it is necessary to consider and include the following Principles; He, Elliot, observes that any effective model should be informed and developed thus.

- a) Be **inclusive** of the range of interests in the service that is the focus of accreditation;
- b) Have a **patient/client-focus**;
- c) Have **methodological rigour** and draw on the **evidence base** in the development of standards and in the processes used to assess levels of performance;

¹This definition is taken from the glossary of version 1 of the International Society for Quality in Health Care (ISQua) standards for accreditation programmes, 1999.

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- d) Be about **excellence** and show a **commitment to quality improvement**;
 - e) Have **sound governance**;
 - f) Be subject to **evaluation and external quality assurance**;
 - g) Be **aligned** with the system that regulates and performance manages healthcare and be **recognised** as being part of that system. In particular, they should be based on NICE quality standards and contribute information to support registration by the Care Quality Commission;
 - h) **Demonstrate value for money**.

This is the model devised and favoured by International Society for Quality in Health Care (ISQua) for the purpose of describing high quality in clinical service accreditation schemes.

Elliot (2009).

The model breaks down as follows:

3:7. Inclusiveness

The development, delivery and governance of clinical service accreditation schemes should:

- Be a partnership between the medical and non-medical professions and professional associations whose members make a substantial contribution to the clinical service that is the focus of accreditation;
- Fully recognise the contribution of social care if this is relevant to the clinical service;
- Take account of the perspective of non-clinical managers, commissioners and policy-makers;
- Work in partnership with patients, carers and third sector organisations that represent patient and carer interests. This includes having patients as full members of project teams, advisory groups and peer-review teams and involving them fully in the development of standards and methods.

3:8. Service User Focus

When applicable, accreditation should consider clinical services from the perspective of service users, their families and their carers. Accreditation standards and performance assessment should:

- Cover the rights of service users to: dignity and respect, recognition of their cultural and spiritual needs, privacy, confidentiality, information about treatment and care, informed involvement in decision-making and the exercise of choice;
- Consider access to and discharge from clinical services; including for those with disabilities and special needs;
- Consider the service user journey through care with deliberate attention to the interfaces between different components and levels of clinical service;
- Require that treatment and care are individualised to the needs of each patient.

3:9. Methodological Rigour:

Accreditation is a formal judgment about a service which cannot be regarded as reliable until the programme itself is validated. This requires that standards and procedures for assessment and reporting are developed systematically and tested thoroughly. This may take several years. This development and testing should be an ongoing process.

3:10. The Accreditation Standards

Elliot observes that from the perspective of his research, clinical service accreditation schemes should apply the principle proposed by the International Society for Quality in Health Care (ISQua) and cited in Elliot (2009) that *“standards are planned, formulated and evaluated through a defined and rigorous process”*².

Standards, Elliot believes, should always be reviewed regularly and, when necessary, revised in the light of, for example, new evidence or policy. In this way he believes that this will drive improvement, the level of performance stated by the standard might be raised between review cycles or new, more exacting standards added. Also, standards might be ‘graded’ into, for example, those that are: i. **essential** - failure to meet would result in a significant threat to patient safety, rights or dignity and/or breach of the law; ii. **Expected** - standards that an accredited service would be expected to meet; iii. **Desirable** - standards that an excellent service should meet. Elliot (2009)

²International Society for Quality in Health Care (2007). International Principles for Healthcare Standards, Third Edition. ISQua: Victoria, Australia.

3:11. Commitment to Quality Improvement

For Elliot service accreditation should both work at a level above that of assuring compliance with minimum standards and drive improvement in quality.

*"While we have robust systems in place to ensure that minimum standards of care are met through regulation, there is no coherent or comprehensive approach to recognising leading teams that are providing excellent standards of care. One way of recognizing the teams that meet such levels of excellence is through greater use of accreditation. This has the potential to unleash healthy competition among clinicians across the country to provide the best care."*³

3.12: Governance:

For Dr. Paul Elliot, governance centred upon the foundations of leadership, support services and service delivery⁴ paying particular attention to criteria that ensure that:

- All decision making and behaviours are guided by a code of conduct that avoids conflicts of interest;
- The assessment process is transparent and independent;
- The determination of the outcome of the assessment is transparent, consistent, relevant to the scope of the accreditation, made purely on the basis of the assessment report and independent of the assessment process;
- Peer assessors are selected carefully, trained adequately and have their performance evaluated;
- Peer assessment teams provide a balance of skills and experience to match the needs and characteristics of the clinical service being accredited;
- There is an appeals process that is transparent and described clearly;
- The Public has access to information about which clinical services have been accredited.

Elliot (2009)

The authors concur with such a detailed, responsible and effective approach. It ensures that the importance of practice and a strong sense responsibility are delivered based upon recognised and identified needs, best, effective and unfolding practice in the face of the environments faced by those involved in organisations engaged in the field suicide prevention, intervention and postvention.

3:13. Evaluation and external quality assurance:

Here the approach is taken that organisations are honour bound to practice what they preach particularly when it impacts of the quality of their work and the service they provide. They should;

- State explicitly the standards to which they aspire;
- Engage in self-review of their performance against these standards;
- Participate in external peer-review; both by being subject to assessment by peers and by contributing their staff to act as peer assessors of other service accreditation schemes;
- Make public the results of assessment of their performance;
- Participate actively in research about the effectiveness of clinical service accreditation schemes in bringing about improvement in clinical services. (2009)

Elliot goes on to argue that in terms of alignment all professionally led services must ensure that any practices or accreditation should be aligned to other qualitative services and practices thus ensuring a maximum sense of impact on the quality of practice and service. In this way the burden of data collection, he observes is minimised. (2009)

3:14. The American Model:

The American Association of Suicidology (AAS) established an accreditation model in 1976 and has developed the process, with the support of the voluntary sector, since that time. The AAS states that it strives in its accreditation process to "recognise exemplary crisis programmes" in the area of suicide prevention. The American Association of Suicidology defines the accreditation process as both evaluative and supportive in assisting applicants to reach their optimum potential within the standards established for accreditation. In their 2010-2011 accreditation manual they state:

"The purpose of accreditation is not to exclude programmes, nor to stifle, frustrate, or punish agencies. Rather, minimum standards are meant to stimulate agencies to strive for higher levels of functioning, to teach optimum standards of service, not to become complacent with having met minimum standards. To this end the accreditation process

³NHS Implementation Team (2009) High Quality Care for All: Our Journey so far. Department of Health: London, p.38.

⁴International Society for Quality in Health Care (2007). International Accreditation Standards for Healthcare External Evaluation Organisations, Third Edition. ISQua: Victoria, Australia.

focuses of self-evaluation, learning and sharing as ways to improve service" (Standards Manual: 7)

In considering the value and purpose of accreditation the author must view it from the viewpoint of a coupling of its effects with an authentic sense of quality assurance that should be interwoven through any valuable or effective accreditation process.

3:15. Evaluating Practice

The value that an organisation places on one thing, way of doing things, or way of being, forms the context for evaluation. It is a tool that offers organisations the opportunity to affirm activities and practice, may result in continuing with existing practice, or may result in new practice choices, new activities and creativity or innovation. Engaging in evaluation can be considered as *"creative, enabling, inclusive and socially innovative"* (Squirrell: 2012)

Evidenced based practice aims to investigate "what works" and the development of policy and allocation of resources is founded on the results of the investigation. Evidence based practice is considered to have a number of elements of which the following are important in considering the context of this research. Evidence based practice:

1. can indicate whether initiatives can be successful
2. what conditions offer the best opportunity for success
3. testing of new ideas
4. offer an opportunity for needs analysis
5. indicate programmes that offer best use of critical resources
6. support transparency and accountability
7. offer an opportunity for greater degree of reflection about practice and organisations

In seeking to move this practice successfully forward it is important to give due emphasis to the following considerations in developing a model of practice

- **Support** the exploration of meanings and good practices within the agreed processes.
- **Identity** resources intended and additional and support needed to ensure good practice.
- **Planning** a timetable of action on what needs to be done through agreed determination
- **Carrying** through the aims and objectives of the process and programme
- **Reviewing** the practices and procedures at regular intervals.
- **Discuss** goals and activities, suggested, possible and in place.
- **Learn** from all layers and levels of experience.

3:16. The Effectiveness of Accreditation

As in any development of models of accreditation it is important to identify and consider any factors that will add to the basic effective nature of accreditation. Such factors include clarity of purpose, method and approach, sustainable funding and resources. Coupled with these one might ask of the accrediting body what accreditation offers and delivers to groups who seek such accreditation from it? How balanced and transparent is its own approach and practice to groups and organisations involved in the identified area of practice and work?

3:17. Quality Assurance

It is useful to offer a definition of both Quality and Assurance before exploring definitions of the phrase itself. Quality, according to the Oxford English Dictionary, is, *"a degree of excellence"*, with Assurance defined as *"a formal degree and positive declaration."* According to Williamson, (1979) *"Quality assurance is, the measurement of the actual level of service provided, plus the efforts to modify when necessary, the provision of these services in the light of results of the measurement."* Therefore in defining quality the authors caution that an awareness of the subsequent elements is important.

Inferred output:

- Process of practice and involvement
- Examination of case work and supervision
- Training and education of management, staff volunteers

Inferences from outputs:

- Reports and reviews
- Ethical investigation.

Put in its simplest terms, organisations, as observed by Sale (2005) can approach the consideration of quality from both an acknowledged and unacknowledged stance with quality itself judged upon the predication that there is improvement and that reparation lasts over an appropriately extended period of time.

The quality assurance process breaks down into four stages

1. *Preparing to take part in the quality assurance process;*
2. *Meeting to agree a commitment to take part in the quality assurance process.*
3. *The organisation sets up a quality assurance team.*
4. *Induction: setting out a timeline and expectations for taking part in the quality assurance process.*

Schmadl (1979) argued, in relation to nursing practice in particular, that quality assurance at the essence of its purpose was to, *"assure the consumer...of a specified degree of excellence through continuous measurement and evaluation"*. Whilst Ovretveit (1992) observed that it pertained to, *"all activities undertaken to predict and prevent poor quality"*. For the purposes of this research, the Williamson definition will be offered as a working hypothesis that informs the development of the research and underpins the basis of the accreditation model.

Quality assurance, within the community and voluntary sector must take full cognizance and be informed by the following template as proposed and presented in Lang's cycle of effective practice. It is cited by Sale (2005) and presented as a systematic approach to quality of assurance and care.

1. Identifying values
2. Setting objectives.
3. Describing care in measurable terms
4. Securing measurement.
5. Evaluating results.
6. Taking action-completing the cycle.

With these elements and considerations taken into account in any development of standards and/or practice, the basic truth in relation to services influenced by the above or offered after consideration of them is that they, the services and practices must be accessible, effective, acceptable and appropriate. Koch. (1993) In consequence how the services and practices are organised must take into account the appropriate quality input to ensure

- *management commitment, leadership and capabilities*
- *optimum team work*
- *recognition of staff value*
- *implementation of quality techniques*
- *service and practice audit*
- *standards setting*
- *information, monitoring and review*
- *communication*

In real terms quality assurance equals quality management and this is one of the important dynamics in the evolution of services and practice within any organisation. Sale 2005 suggests that the following model is a simple but effective breakdown of the constituent elements to be considered in assuring quality is delivered.

Determine criteria

Set standard

Devise assessment tools based on determined criteria.

Compare what is with what should be

Quality measured.

Identify gaps

Take action to ensure all standards achieved.

Quality assured.

Consequently, in considering accreditation it must be viewed in the light of a system of quality assurance as a precursor of clinical governance. Sale(2005). Simply framed, accreditation is a continuous quality assurance framework and

central to its purpose and focus is the service user. For the purposes of the research the authors recognised varying degrees of governance required, depending on the level of practice, for organisations engaging in suicide prevention, intervention and postvention in Ireland.

Quality, according to Oakland (1993) must begin at the top and its parameters must inform and be inherent to each and every decision making process or decision taken within the organisation, its structure, its practices and procedures with the need of the service user at the centre and core of any defined approach and practice. In this way, Oakland postulates, quality meets the service users' requirements and is thus defined by the service user and not by those supplying the service. Oakland: (1993).

From Koch there is a note of caution in relation to the need for vigilant reflection when taking into account the difficulties that can arise where there is lack of vision and commitment from top management, lack of structure coupled with ineffective leadership that latches on to whatever practice happens to be flavour of the month, with staff members.

3:18. Quality Assurance and Standards:

Standards are, quite simply, an agreed approach and level of reference that are essentially considered to be appropriate to approach, process and practice in relation to the service user/client and reflect what is determined to be acceptable, achievable, observable and measureable. In real terms they, standards, offer a valid definition of quality of care that consequently are informed by agreed criteria that permits measurement and evaluation of effective practice and the subsequent quality of that practice informed by the necessary level of care.

3:19. In Considering Quality Assurance and Practice:

For Sale (2005) any consideration of quality assurance and standards coalesces around the elements of description, measurement, action and checking. Any practice must be informed by an ethical or moral consideration and any practice is formed from an identified and recognised need. Logically any development is based upon an unfolding philosophy of approach, practice and need. Central to such a philosophy is the consideration of held belief and answering basic questions that will affect our ability to offer and perform any service of value in the area of suicide prevention.

1. Why are we here?
2. What do we believe we are doing?

In asking and reflecting upon these basic queries we can be lead to consider our determined objective which is realised in the question, what do we want to achieve?

The argument for developing such a philosophy of approach is that, as Sale observes, it leads to clarity around the development of standards necessary to our practice and in doing so permits us to record and write down such standards that will influence our process and identify our best practices. (2005)

Measurement can only be authentic and congruent when based upon an accurate description of the standard and its inherent criteria. In this way measurability can be pursued and enacted.

In relation to the area of action, we must primarily consider the comparison of value above feeling, theory over practice, reality with vision. This permits us to determine what should be with what is. In doing so, we can look intently at the strengths and weaknesses of our approaches, processes and practices and adapt them accordingly. This opens us to an assurance of quality of care in our sphere of practice and influence. In the final analysis standard setting should always compare current practice with the set standard ensuring that if there has been a lack of achievement we ask the fundamental question why? If our standards are realistic and achievable such a question need not arise.

3:20. The Setting of Standards

As earlier mentioned the authors observe that in order to set out practical and effective standards of practice and accreditation they must be informed by current practice and compared against such practice as the current benchmark in the field of suicide prevention, intervention and postvention. This should permit the honest consideration of whether not current practice is effectively meeting need and addressing the issues of the day. Is current practice and the processes that inform it rooted in the reality of the clients experience and is it informed by this or is it predicated upon guidelines visited upon it by non-practitioners without understanding of the work being carried out in the field of suicide prevention?

Realistic and achievable standards of accreditation will be best informed by those who deliver the service they pertain to. These practitioners must be actively involved in the gestation and the delivery of such standards and have a hand in the final wording and tone of them. For, observed by Sale, in seeking to set standards we automatically open up the debate and discussion around current practices and processes.

By opening up the discussion and debate, this allows the authors contend a developing and sharing of our various experiences, practices and approaches to our work and allows us a shop window in which to place our expertise for consideration and constructive suggestion and criticism. These actions alone can and often do improve quality of practice and service.

3:21. In Considering Governance

In order to consider governance we must first settle upon a working definition for the purposes of this current research. Governance may be viewed as *a systematic approach to managing quality assurance and quality control within the services provided or offered by any organisation*, Sale 2005.

If we accept this premise as our definition it becomes vital that the development of any approach to this finds its' foundation within recognisable principles and parameters of quality assurance. Further to this, consideration must be given to how this can effectively be applied to any practice and process within any organisation engaged in preventative practice in the area of suicide.

To this we add the vision of governance as *a mechanism of leadership, decision making, information sharing and accountability to an identified accrediting or governing body*, (Sale 2005). If we couple these strands of definition together we are left with the responsibility to ensure a shared sense of ownership and responsibility on the behalf of participants, service users, management, staff, volunteers and the organisation as a whole.

This approach is central to any attempt to develop recognisable standards and in determining how practice might be measured in order to further develop and improve services and results subsequently attained. Sale (2005).

3:22. Governance: purpose and aim.

The importance and purpose of governance lies in its ability to ensure there is an effective, holistic quality of service and care offered for the benefit and wellbeing of service users and participants. It is expressive of the desire to ensure openness to the following considerations.

- *Protective and risk factors.*
- *Management of risk.*
- *Continual and open audit of practices, programmes, processes and services.*
- *Gauging the effective nature of practices, programmes, processes and services.*
- *The effect on staff and volunteers.*
- *The need and purpose of on-going and unfolding training, education and development at a personal and professional level.*
- *The development, consideration and regular assessment of information in the support of delivery of programmes, processes and services.*

Adapted from Sale (2005:31)

In simple terms this is the very essence of a necessary framework that permits the encouragement, development and maintenance of a quality of service steeped in good practice and good governance.

3:23. In Considering New Technologies

In an age of ever changing methods of communication the traditional methods and approaches to suicide awareness and prevention have been augmented by smart phones, the internet, social networking sites and their all-pervading presence among the local and global populace. These new technologies permit us to pursue new methods of interaction and intervention within the field of practice.

These new technologies have opened up our ability to effect and affect thinking and awareness around suicide prevention. There has also been a growth in organisations whose practice is solely based in and through the new technolo-

gies mentioned above. Those with access to the internet can have immediate access to information and assistance unencumbered by a busy phone line or a physical wait for an appointment with a practitioner.

The internet can offer almost immediate access to information about practices, interventions, suicide awareness programmes, and contact details. Depending on the need one can access self-help information, programmes and treatments. Access to information needed to help others is also readily available. The biggest advantage of any web based programme or organisation is that the user can have twenty four hour access as and when it is needed, an advantage that can tide them over until they have an opportunity to meet with another person physically and face to face.

They have access to forums and blogs staffed or informed by experts or practitioners in the field, engaging by interactive social media to community programmes and help groups.

It is, we contend fair to acknowledge that, such engagement has informed and been incorporated into the practices of a number of organisations in Ireland, with, some solely accessible through the web based programmes. Such programmes offer a connection to an interactive environment for those in immediate need of assistance or advice.

Social networks such as Facebook, Skype, and My Space permit the creation of profiles and links to friends or contacts. Consequently this permits access to communication on a personal, social and community level through, for example instant messaging. Mobile phones can permit an instant text to go to another who may be of assistance or of comfort to the person suffering the complexities that come with suicidal ideation. Such networks offer the opportunity of social connections to others, family, friends and peers at any given time of the day or night and this is a very real advantage for suicide prevention permitting a constant outreach to the person in need.

It is, we observe, true to say that the new technologies offer a very real and important resource within the field of suicide prevention. This can only develop and grow over time as such modes of communication develop and grow. However, we must add a caveat to this observation. Much as such technology and web based programmes offer invaluable support and service there can be no replacement of the person placed and centred approach or the physical presence of one to another within a shared space of intervention. The research also recognises the vigilance required to monitor the more sinister aspects of web based technologies, those engaged in encouraging suicide and those enabling cyber bullying.

3:24. Organisations and Change

“Organisations in change are those where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together” Senge (2006)

The manner in which organisational learning occurs has been widely developed since the early nineties when the concept was popularised as a method of exploring organisational responses in an ever changing environment. (Senge: 2006, Squirrell: 2012). The need for organisations to be proactive and adaptable was highlighted and the vision of a learning organisation is captured in the above quote. Dale (1994) argues that rather than trying to find a blueprint for the learning organisation it is more important to identify the key features that support a learning organisation in the process.

Features identified include supporting organisations to *“develop rather than just become”* a learning environment (Senge: 2006), organisations that support the development of individuals as well as the organisation itself appear to be more successful at engaging with evaluation and change. Additional elements include, open communication both inside and outside the organisation, commitment to responsiveness and innovative practice and those organisations not bound too tightly by regulations and procedures, where there is the possibility of fluidity and opportunity to learn from feedback.

Patton, M. (2001:30) considers little value in evaluation of practice if it is not used. Patton's view is that there is greater long term benefit to organisations than short term as short term outcomes of evaluation may have limited shelf life. He argues that organisations that are receptive to the process of evaluation have potential to greater learning and potential for change. Evaluation of practice, establishing quality standards and accreditation models can help the on-going development of an organisation and its work.

3:25. Organisations

It is useful to understand the dynamics of organisations and the formulation of organisational identities. Organisations are created by humans and the values, ethos, culture, identity and methods of operation are shaped by the people within the organisation. Organisations evolve, deliberately change, and can get embedded in a pattern of operation. Stacey (2005) states *"patterns of human interaction produce further patterns of interaction"*. Organisations are influenced by the way people behave, individuals identities and anxieties and peoples capacity for change.

"A groups identity is linked to defining its primary task- its reason for existence (Rice, 1963)...in organisations caring for people, identity and tasks are often linked to ideals and ideology...since the personal meaning of the work tends to be vested in the ideal underlying the choice of working methods, it can be very anxiety provoking to question them. Instead of space to reflect on what is most appropriate for whom there is often polarisation about right or wrong". Roberts, 1994:114

The above is useful in that it captures how people in/and involved with organisations become intimately intertwined and defined by each other. In the community and voluntary sector there is often limited opportunity for personal/professional reflection and for organisational learning and growth. For some people in organisations, the potential of an evaluation, a quality standards and accreditation exercise models may be perceived as a threat, that judgement may be passed or that the integrity, skills and professionalism of the organisation and individual may be questioned and undermined.

Roberts (1994:32) states: *"Many organisations are set up as alternatives to other, more traditional ones, by someone disaffected by personal or professional experience or other settings. However, identity based on being alternative, superior, by some ethical or humanitarian criterion tends to stifle internal debate. Doubts and disagreements are projected fuelling intergroup conflict..."*

Evaluation, development of quality standards and accreditation can be tricky in such circumstances. It is recognised that many of those community and voluntary organisations, working in the suicide prevention, intervention, and postvention sector in Ireland, developed and evolved as a result of tragic personal and community experiences. An evaluation and development of accreditation models can be perceived as intrusive and may result in organisational defences.

It is imperative that organisations are ready for evaluation and the development of quality assurance processes and models. If the level of "readiness" is poor then regardless of the effectiveness of the process, the experience may be regarded with suspicion and as an invasive process. *"Without seeking to know about its effectiveness, a group inevitably loses its capacity to adapt and to develop...the importance of fostering a spirit of enquiry within organisations, so that evaluation can become a tool for learning from experience."*

Obholzer and Roberts, (1994)

3:26. Perspective and Change

Senge (2006) develops a number of valid points concerning organisations and the experiences of individuals within them. He argues that people are taught to be *"loyal to our jobs"*. This he observes causes individuals to confuse their role with their identity, can lead to a loss of perspective and can sometimes result in a narrow vision and perspective. People with this experience can become too narrowly aligned only with their role and can fail to see the wider picture or system. Such employees *"hunker down"*, blame others and can fail to take the purpose of their job, the organisation, and the system into account.

Such faulty thinking can perpetuate problems, increase resistance and can leave organisations feeling stuck, looking at single events, and forgetting about the bigger system, emergence of patterns and possibility of change. Change management in organisations is essential to the development of structures, resources and practice and the evolution of and improvements of services.

Whilst it may be acknowledged that change is a positive outcome of learning and evaluation; some organisations, and the people within, prefer stability or status quo thus resisting openness to the possibility of change. This is described as *"Dynamic Conservatism"* (Dale: 1994). Dale posits that dynamic conservatism differs from stagnation. Organisations which stagnate face a systemic inability to change. Those organisations which experience dynamic conservatism are resistant to change, experiencing anxiety and panic as they feel the change will expose habitual methods of routine

practice and day to day activities that are unquestioned. Organisations that are resistant to change can retain familiar patterns missing the opportunity to engage in learning, developing systemic understanding and change.

Supporting change in organisations is complex and can evoke anxiety; and as Squirrel (2012) argues, it is beneficial if change process can be considered as having a number of elements:

- Change is an organic and normal process not one to be threatening
- Organisations can participate in the process of change, at all levels, change is not imposed without the consideration of all those in the organisation.
- Change process can be allowed to emerge, be evaluated as it processes, can be corrected, and questioned.
- Change has a focus and a sense of direction, is not simply a reaction to events
- Change process does not blame or devalue how practice was carried out in the past; the past is acknowledged and built upon, particularly when considering how people have a sense of identity connected to and within the organisation.
- Change process must acknowledge the perceived threat; the challenge and anxiety faced by those in the organisation and must offer space to allow for feelings.
- Time and resources must be committed to enable the development of new working practices.

It is evident that effective evaluation, accreditation models and quality standards can be devised but the business of developing such standards must take account of the “process” for organisations and individuals within them. It is important to develop a strategy to ensure minimum adverse impact on staff, to ensure skills and confidence for those managing change within organisations, that there is a high level of involvement from the suicide prevention sector and that effective communication takes.

3:27. In Conclusion

In any attempt to develop a thoughtful, reflective and effective model of accreditation for organisations working within the Preventive, Interventive and postventive sectors in the field of suicide, it is of prime importance to ensure a careful and determined assessment of all the vital and important areas that seek to inform and be imbedded within such a model. Consequently such an assessment should seek to consider the Situational, the Clinical and the Social aspects and requirement of people’s experiences.

1. The Situational should be considerate of any degree or level of planning and what access those considering the action of suicide have to means. Have they sought to settle their affairs, have they made any previous attempts to take their life through the action of suicide and have they faced any recent or do they face any impending life crisis, physical illness/loss. Ultimately consideration must be given to any possible family history of suicide.
2. The Clinical must be considerate of any medical diagnosis of depression and further to this must give thought to the client’s possible use of illicit drugs or any developed level of alcohol dependence. The question may pertinently be posed as to any personality disorder, clinical signs of hopelessness, anger, restlessness, compulsions, bitterness experienced by the client when they find themselves actively considering the act of suicide as a viable option.
3. Finally consideration must be given to The Social Aspect of the person’s life and lifestyle. What is their status? Are they married or single, widowed or separated. Do they have property, do they share a home with others, are they still living at home or do they indeed find themselves homeless or living alone. What, if any, support networks can they avail themselves of and if male do they have significant others with which to share their thoughts and feelings?

For as Americas National Strategy of Suicide Prevention observes,

“Suicide is a particularly awful way to die, the mental suffering leading up to it is unusually prolonged, intense and unpalliated.The suffering of the suicidal is private and inexpressible, leaving family members and friends and colleagues to deal with an unfathomable kind of loss, as well as guilt. Suicide carries in the aftermath a level of confusion and devastation that is, for the most part, beyond description.” (NSSP 2001)

4. Methodology

4:1. Data Collection Methods

The aim of this research is to use mixed (qualitative and quantitative) methodologies to research existing quality standard systems and to develop an accreditation model for voluntary organisations in Ireland working in the area of suicide prevention, intervention and postvention. Such a methodology gifts the authors an explicit method to conduct, review and evaluate current practices and procedures. This offered an opportunity to effectively connect all the issues at every level for the deeper and broader purpose of developing an authentic understanding of the issues, of the practices engaged in and by the participant organisations and from this to move toward the overall product of a set of accreditation standards for voluntary suicide prevention organisations in Ireland.

In considering an effective methodology for the research the authors were keenly aware of the imperative not to engage or collude in selecting methods designed to produce misleading results or that would lead to an erroneous consideration or misinterpretation of information and/or findings by commission or omission.

Data collection methods:

A mixed method approach was determined for this research. Data collection encompasses a literature review, questionnaires, and semi-structured interviews within the sample organisations/groups. In consultation with the expert group and the IAS a review of agreed procedures and organisation structures, governance and processes was evaluated. This further incorporates a triangulated multi method approach.

Triangulation, according to Bryman (2004:275) *“entails using more than one method or source of data in the study of social phenomena”*. Hamersley 1996 (cited in Bryman 2004:455) defines triangulation as the *“use of quantitative research to corroborate qualitative research findings and visa a versa”*.

The authors contend that, where material and answers to the research questions are already within the public domain, the suggested methodology will enhance and permit a revision of initial material and research thus permitting a logical continuance of the other phases of research. Practice informs us, the questions asked during research are informed and suggested by issues highlighted within the discipline of literature and practice.

There was a gradual integration of methods in which the practice was to select and systematically integrate only those pertinent and appropriate techniques from both the qualitative and quantitative perspective to permit a more thorough investigation of the issues and practices.

Consequently, those organisations considered for involvement in this research met a set of inclusive criteria for participation in the research centres upon identified professionally practicing organisations working within the field of suicide prevention on the Island of Ireland.

- They have to currently practice nationally, regionally or locally.
- They must adhere to a code of good practice and behaviour and accepted professional standards.
- Their practice and approach must reflect this code of good practice and standards.
- They must be involved in preventative, postventative or Interventive practice.
- They must be recognised as professional practitioners in the field of suicide prevention work.
- They must evidence good governance and effective management structures that inform and guide their practice and activities.

Denscombe (1998:84) states that the use of multi methods can produce different kinds of data on the topic, allowing the researcher to see things from a different perspective. The topic can be seen in a more rounded and complete fashion: permitting the researcher to arrive at valid findings, comparisons and conclusions.

Bell (2005:117) however implies that the methods of data collection selected need to be looked at critically, to assess if they are valid and reliable. Bell goes on to state that reliability is the degree to which the methods are used; and that they may produce similar results no matter when and how often the methods are tested. Validity informs the researcher if the tool used describes what it was supposed to do. Sapaford and Jupp (cited in Bell 2005:117) take validity to mean *‘the design of research to provide credible conclusions; whether the evidence which the research offers can bear the weight of the interpretation that is put on it’*.

The use of a mixed method approach gave authors the opportunity to add reliability and validity to the study; in turn providing a credible conclusion, which will stand the weight of the interpretation put on it.

4:2. Action Research

There is a body of evidence that states action research is associated with practical issues, and a process for collecting, investigating and interpreting data to answer questions. Denscombe (cited in Bell 2005:8) explains that research is to arrive at a suggestion that will enable an organisation or individual to tackle an issue, which in turn will enhance their practice. Punch (2005:160) proposes that action research aims to design inquiry, to build upon knowledge, to use the service of action to solve a particular problem.

Action research commences from the thought of a specific problem or question. Hence the purpose is to direct action to solve a realistic problem or solve a realistic question.

Action research *“seeks to bring together action and reflection; theory and practice, in participation with others, in the pursuit of a practical solutions to issues of pressing concern to people”*. Greenwood and Levin (cited in Blaxter et al 2001:67) go on to say that action research is holistic; it produces tangible and desired results for the people involved; producing insights both for the researcher and the participants. Reason and Bradbury (cited in Punch 2005:160)

Denscombe (2001:58) also identifies action research as *“driven by the need to solve practical and real problems”*. Linking with Kumar’s (1999: 2) view that action research is a way of thinking; whereby you critically examine various aspects of your practice. In doing so providing the opportunity to develop and test new theories to enhance the profession. The authors have encompassed the different views put forward by the various authors’ accounts of action research; and believes that this approach is central to their study.

There are two primary types of research: qualitative, quantitative. Qualitative and Quantitative approaches should not be viewed as polar opposites or dichotomies: instead they represent different ends on a continuum (Newman and Benz, 1998). A study tends to be more qualitative than quantitative or vice versa. Mixed methods research resides in the middle of this continuum because it incorporates elements of both qualitative and quantitative approaches.

4:3. Quantitative and Qualitative research

Quantitative and Qualitative research strategies are widely used within the realms of social research. Punch (2005:2) states that Quantitative and Qualitative research methods are the two central approaches in social research today. A simplifying of the research methods will provide the researcher with the knowledge required to establish which method best suits the study.

4:4. Quantitative Research

Quantitative tends to deal with the information collected in measurement or numerical data and also tends to have a specific focus. This research approach permits large sampling to be investigated, the larger the more reliable the outcome, allowing inferences to be made to the wider population (Silverman, 2005). Although this is an advantage it can also be a disadvantage as it leads to the assumption that outcomes are consistent and the same for all the people all of the time. *“Large volumes of quantitative data can be analysed relatively quickly, provided adequate preparation and planning has occurred in advance. Once the procedures are up and running researchers can interrogate their results relatively quickly”*. (Denscombe, 1998, pg.205)

Quantitative research is perceived to be more scientific and objective, as it uses numbers and can be presented in the form of graphs and tables Denscombe (1998:177). Creswell (2003:18) points out that quantitative research collects data on predetermined instruments that yield statistical data. The quantitative researcher is thus concerned with applying measurement procedures to the social world, they are uninvolved with the participants and they determine the structure.

The function of quantitative research is to measure phenomena so that it can be transformed into numerical data which can then be analysed using statistical techniques. These techniques are reliable: however they are dependent on the input of numerical data. With quantitative study the researcher will establish hypotheses with a predetermined research design (Denscombe, 2007). Although this permits precision, control and replicability which contribute to the validity and reliability of the method, it fails to take into consideration people’s unique ability to interpret their experiences and construct their own meanings (Creswell, 2003).

As alluded to earlier, quantitative research, some historical precedent exists for viewing a theory as a scientific prediction or explanation. For example, Kerlingers definition of a theory is still valid today. He said, a theory is *"a set of inter-related constructs, definitions and propositions that presents systematic view of phenomena by specifying relations among variables, with the purpose of explaining natural phenomena"* (Kerlinger, 1979, pg. 64).

A theory may appear in a research study as an argument, a discussion, or a rationale and it helps to explain or predict phenomena that occur in the world. Labovitz and Hagedorn add to this definition the idea of a theoretical rationale which they define as *"specifying how and why the variables and relational statements are interrelated"* (Labovitz and Hagedorn, 1971:17).

A further consideration on aspects of theories centres upon the manner in which they vary in their breadth of coverage Newman (2000) reviews theories at three levels; *Micro – Level, Meso – Level and Macro – Level*

Micro Level theories provide explanations limited to small slices of time, space or numbers of people, such as Goffmans theory of face work, which explains how people engage in rituals in face to face interactions.

Meso Level theories link the micro and macro levels. These are theories of organisations, social movement, or communities such as Collins theory of control in organisations.

Macro Level theories explain larger aggregates, such as social institutions, cultural systems and whole societies. Len-ski's macro – level theory of social stratification, for example explains how the amount of surplus a society produces increases with the development of society.

Bryman (2004:286-287) list of common contrasting features of quantitative and qualitative research, put forward that the use of a questionnaire deems the study to be quantitative as the research is distinct and uninvolved with the participants. Denscombe (1998:220-222) proposes an inclusive critique of the advantages and disadvantages associated with quantitative analysis. On examination of the advantages and disadvantages the authors are of the opinion that a quantitative approach is, in part, applicable to the study.

4:5. Qualitative research

Bell (2010:5), states that a qualitative perspective relates to the understanding of an individual's perceptions of the world. Punch (2005:5) puts forward the view that qualitative research is empirical research about the world where the data is not in the form of numbers however it includes words, pictures and visual aids. On from this Matthew and Ross (2010:145) propose that a qualitative approach will provide the researcher with the opportunity to explore issues in more depth with the participants in their own words. Consequently qualitative data is concerned with the understanding of the social world, by examining the participants' view of the world.

Qualitative research is focused towards finding the meaning and addresses the meaning of centred questions that are not easily quantifiable.

"Qualitative implies a direct concern with experience as it is lived or felt or undergone... qualitative research then has the aim of understanding experience as nearly as possible as its participants felt it or live it". (Sherman and Webb, 1988: 22)

Bell states *"doubt whether social facts exist and question whether a scientific approach can be used when dealing with human beings"* (Bell, 2005: 7)

Qualitative research uses multiple tools that help to look for the understanding rather than statistical perceptions of the world, using people, things, and events in their natural surroundings to assemble their knowledge. Punch (1999:139) refers to qualitative research *'as not a single entity, but an umbrella term which encompasses enormous variety'*.

On the premise of the views put forward, the authors believe that a qualitative approach has enhanced the study. The use of a focus group to augment existing data will provide the authors with the opportunity to explore issues in more depth with the participants in their own words. Furthermore the approach taken has, and remains interactive and humanistic, enabling the authors to accumulate understanding and knowledge from the participants in a natural setting.

4:6. Mixed Method Approach

As stated a mixed method approach will be selected for this research. Fundamental to any research are the principles

of validity and reliability. Validity refers to the extent to which the data collected truly measure what is claimed to be measured. If the data collected is not correct or reliable then the results are incorrect or not representative. In order to strengthen the reliability of research many tend to use triangulation. This refers to when mixed methods of data collection are employed in order to achieve diverse view points on a topic (Olsen: 2004).

Combining qualitative and quantitative methods in research attains complementary and the appearance of overlapping different aspects of phenomena (Greene, Caracelli and Graham, 1989). Mixed methods have the advantage of deep description and 'lived' realities of participation investigated by the qualitative methods. They also have the potential to contribute to the general liability and statistical reliability that is the potency of quantitative research (Borkan, 2004).

This method of research can provide narrative to add meaning to numbers but also use numbers to add precision to narrative data (Connolly, 2009). Olsen (2004) describes the mixing of methodologies, such as focus groups and interviews, as a profound form of triangulation which is the methodology which the researcher will use within this study.

Variables - A variable is a condition or position that can be changed and/or influenced, such as a characteristic or value (Bell, 2005). Variables are generally used in psychology experiments to determine if changes to one thing result in changes to another so as to make casual inferences or correlations. Research is the study of the relationship between variables, therefore, there must be at least two variables or there will be no relationship to investigate.

A variable is a changeable factor that includes factors such as gender, ethnicity, weight or age (Denscombe, 2001). In relation to the current study the reader must be aware of hostile reactions to and an over willingness to agree with answer's given by friends of those already interviewed. Failure to be very aware of this could lead to a tainted sample which would actually distort the findings. In reality one would expect to find some negative feedback from within the population of those from a divided and economically deprived area, however one would also expect to see some positive feedback from within an area which is well known for its humour.

To minimise the chances of peer pressure being attached to the respondents, each respondent was informed of what Straits and Singleton Jr (2005) observed *"experimental studies long may have been regarded as the optimal way to test casual hypotheses. Even when a true experiment is impractical or impossible to some other approach must be used, the logic of experimentation serves as a standard by which other research strategies are judged"* (2005:203).

Data Collection - Data collection is the process by which data is gathered. The method that is chosen will provide the type of data required in order to complete the research (Bell: 2005). There are many various different methods of data collection. Included among these are Question design, Questionnaires, Electronic Questionnaires, Focus Groups and Interviews.

For this piece of research the authors chose the following methods of data collection and will give a brief description of the importance of these methods.

Electronic Questionnaire delivered through Survey Monkey and distributed to sixty participant organisations drawn from national, regional, local organisations involved in Pre/Post and Interventive work in the field of Suicidology throughout the Island of Ireland. Subsequently thirty of these organisations were chosen for visitation and interview using a semi structured interview process coalescing around pertinent identified areas for suitable questioning and consideration.

SPSS - As a programme for statistical analysis SPSS is a model widely favoured within the sphere of social science. The authors acknowledge that there are multifarious methods and practices within data analysis one as legitimate as the other from which congruent and authentic responses may be drawn.

For the authors SPSS was settled upon as the method of choice as it permitted the authors to highlight a clear order of any variables that may emerge and occur within the research. If the authors use for an example the ordinal variable as it pertains to the proposed research; it permits a consideration of difference observed through the mode of ordering. Simply put Ordinal Data is the use of numbers (or words, but usually numbers) that can be ranked ordered or scaled. E.g. the data can be ranked or categorised, low, medium and high and permits a classification of the participant organisations which permits a consideration of spacing that may occur across the various levels. Some examples of ordinal data are

-
- The place finished in a race (1st, 2nd, 3rd, etc.),
 - Degrees of happiness (sad, neutral, happy),
 - Schools (elementary, middle school, high school, college, etc.).

However these do not subsequently express a degree of magnitude or interval. We could not say for instance that someone who felt neutral had twice as much, “happiness” than a person who was sad. From this the authors acknowledge that this variable permits the ranking and ordering of organisations by their level of practice and depth of experience.

As it relates in terms of numeric data, i.e., those that can be ranked ordered or scaled, these express a degree of magnitude that have consistent intervals. Some examples of numeric data are test scores, time, and height. Note that with the numeric data of time, 40 minutes is twice as much as 20 minutes, and that the amount of time between 20 to 40 minutes is the same amount of time as the amount of time between 40 and 60 minutes. Consequently the authors have further settled upon the use of the Likert scale in the development of pertinent questions to the research. For the authors it is fortuitous that the distribution of our sample falls within the central limit theorem as it is suggested that in this way normal distribution occurs.

4:7. Data Analysis

This permits the authors to engage in the processing and inspection of data and to subsequently model data in the pursuance of the goal of highlighting useful information pertinent to the objective of the research. It is hoped that in pursuing this model to identify suggestive conclusions, and support subsequent decision making in relation to development of accreditation standards.

4:9. Semi Structured Interview

A valuable tool in the field of social research is the interview. Denscombe referring to it as an *“information gathering tool”*, states that it, *“lends itself to being used alongside other methods as a way of supplementing their data-adding detail and depth”* (Denscombe 1998:112)

Denscombe further views the interview, in terms of follow up to a questionnaire as the opportunity to flow on from *“some interesting lines of enquiry researchers can use interviews to pursue those in greater detail and depth”*. (Denscombe: 1998:112).

The semi structured interview allows for more flexibility with the introduction of further questions along the way. Although the interviewer may have a clear list of issues to be addressed and questions to be answered, Denscombe states that the interviewer is prepared to be flexible in terms of the order of topic consideration and in providing the opportunity for the interviewee to elaborate and develop discussion and ideas and to consider and speak on the issues over a wider basis. (Denscombe 1998:113)

Lindlof and Taylor (2002:195) in reference to the use of semi structured Interview, state that it is beneficial for the interviewer to have prepared an interview guide which is a, *“grouping of topics and questions that the interviewer can ask in different ways for different participants”*. In this way and through this practice, it could be argued, the answers will remain open-ended with a great emphasis on the role and interaction of the interviewee. (Denscombe 1998:113). For this rationale, the authors felt that the place of the semi structured interview was beneficial and indeed pivotal to this particular piece of research. The technique will be utilised with thirty identified organisations (10 national, 10 regional and 10 local).

5. Findings

5:1. Introduction

This organisation would welcome an accreditation model to ensure high standards, both professionally and for the protection of the clients (interviewee).

This report presents the findings from the questionnaire and the qualitative interviews carried out with voluntary organisations working in the areas of suicide prevention, intervention and postvention in Ireland. The questionnaire used as part of the quantitative research is attached as an appendix. The semi-structured interviews were carried out using the following template:

1. *The background to the organisation*
2. *Organisational structure and Governance*
3. *Areas from the questionnaire that you wish to elaborate on/expand*
4. *Support and supervision*
5. *Areas that are considered important in developing an accreditation model for the suicide prevention/intervention and postvention sector- Recommendations*
6. *Perceived barriers to the development of a quality framework*
7. *Self-care and Boundaries for those working in the sector are important. Any views about the articulation of this area in the model*
8. *Is there a vision you have for the development of accreditation in the sector*
9. *How such a model would be managed.*

The information provided by the survey, and the semi-structured interviews were drawn from and presented by those representatives who participated from the organisations sampled. The data has been completed as a self-report by the respondents. Using a number of methodologies the data has been examined and analysed by the authors.

SPSS analysis has been carried out and the subsequent findings have been examined and conclusions identified, drawn out and consequently reviewed. This was complimented by the use of a number of additional validation processes. The data was then subjected to review by a panel of three researchers and responses and answers explored and collated and cross checked for consistency, emergent patterns and themes. Key themes and gaps were then explored and developed during the qualitative interviews carried out with those national, regional and local organisations who participated fully in the research.

The research recognises that self-report surveys have limitations and the findings reported in this research rely on the accuracy of the information completed in the questionnaires and during the semi-structured interviews. There was a range of diverse and disparate organisations who participated in the research process and thus a comparison between organisation responses is not possible. The limitations must be considered when findings and recommendations drawn from the data are taken into consideration.

Returns from questionnaire/survey and semi-structured interviews

The organisations selected for participation in the research were determined using a number of criteria. The research recognised that there is no comprehensive database of all organisations working in the voluntary suicide prevention, intervention and postvention sector in Ireland. It was agreed that a number of sources would be used to determine those organisations which would be added to the sample list.

- The contact list of organisations affiliated and/or members of IAS:
- Those organisations ($n=102$) which had participated in the consultation meetings facilitated by IAS as part of the initial consultation during May 2011.

In order to support an accurate, more focussed and representative selection a number of additional factors were taken into consideration:

5:2. Thematic

- Organisations providing support, education, and mental health and emotional well-being services as a primary function.
- Those organisations offering support and counselling to those experiencing distress were considered for sampling.
- Those organisations who were offering suicide postvention services were included.

- Those organisations involved in offering services using new technologies.

5:3. Geographic

It was considered imperative that sampling ensure a geographic representation and thus, using the IAS contact list ($N=102$), the database was drawn up to ensure that organisations from all four provinces in Ireland were included. It is recognised that while organisations from Northern Ireland would not be subject to any statutory requirement for accreditation, should one develop in ROI, the participation and views of organisations from Northern Ireland were sought. In developing the qualitative phase of research the national, regional and local organisations invited to participate were drafted with geographic factors considered.

5:4. Size/Structure

The research criteria required consideration of organisations ranging from the large national groups to those local and small voluntary organisations in the suicide prevention sector. This purposive sampling procedure sought to ensure that a cross section of groups was invited to participate. The qualitative phase of research included national organisations, regional organisations and local organisations, the criteria informing their participation included levels of staffing within the organisations, the geographic area it serviced and the organisation structure and self-reported history.

A total of 60 organisations were invited to participate in the research process. They were requested to submit a return email as a record of organisation consent as required by University of Ulster ethical procedures. Of the 60 organisations invited

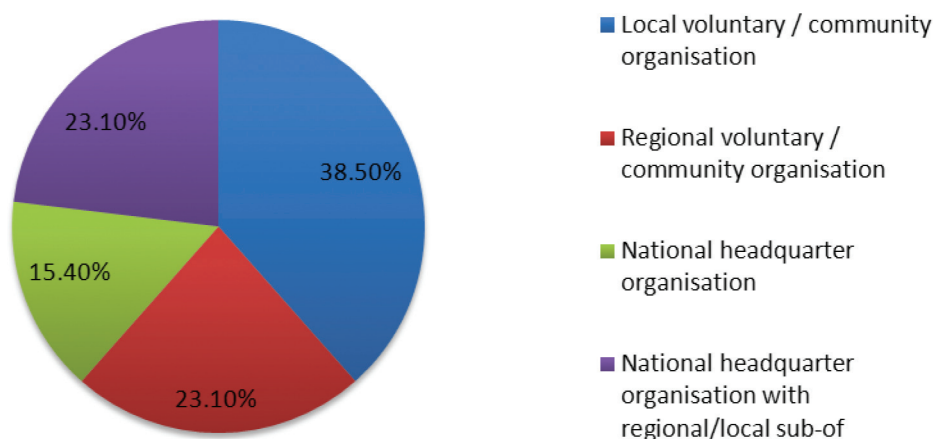
- One declined to participate
- Despite on-going efforts to contact and communicate one appeared unavailable either by telephone/email.
- A second mailing of letter of invitation resulted in a total of 46 organisations responding and submitting informed consent. These organisations were forwarded a questionnaire.

By the 30th of August 2012 a total of 17 organisations had completed the questionnaire and a reminder letter was sent with the closing date extended to the 21st of September 2012.

- By the 21st September 2012, 26 of the 60 groups originally invited to participate had completed the questionnaire.

The second phase of the research revolved around a visitation and interview process with 30 identified organisations national, regional and local. Interviews were carried out and completed with 27 organisations and where required phone meetings and email correspondence occurred when physical meetings proved difficult to arrange due to a variety of reasons such as annual leave or ill health.

Which of these terms best describes the organisation? Percent



Services Provided by Organisations

5:5. Defining the Terms

What is emerging from the research is that organisations working in the sector view their services as concentrated in the area of Mental Health promotion and well-being. The definition used for this research is: *"Mental health promotion is an approach characterised by a positive view of mental health, rather than emphasising mental illness or deficits, which aims to engage with people and empower them to improve population health"*. (WHO: 2004).

Consequently a number of respondents observed that they consider the emphasis on suicide prevention and intervention within the research as stigmatising. Their work is conducted within the parameters of the definition offered above and they engage with service users who require targeted work and intervention.

There are a number of contributory levels that assist organisations in defining or ranking their particular focus of activity within the field. The following three appear to be most commonly integrated into any organisational vision, objective and strategy and are presented for consideration and reflection. They include:

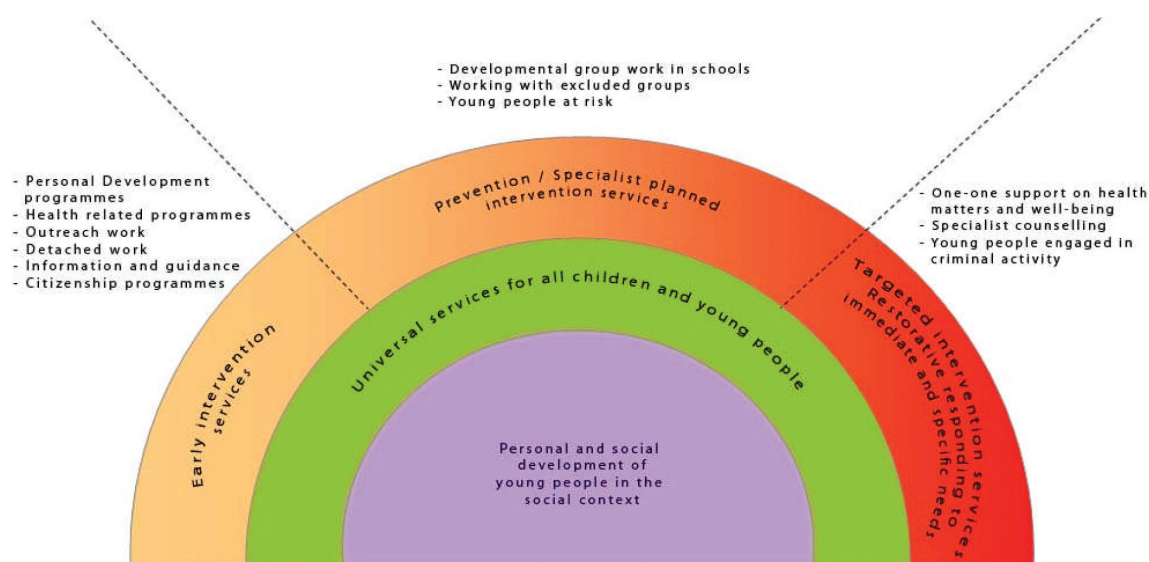
- **Reach Out: Irish National Strategy for Action on Suicide – Levels**
- **Hardiker Model for positioning Services**
- **CLEAR Project: Service Standards and Quality Assessment Framework for Community Voluntary Sector organisations in Northern Ireland define levels**

Reach Out: Irish National Strategy for Action on Suicide incorporates the following levels to define activities within organisations.

- **Level A:** Promoting Positive mental health and well-being in the general population
- **Level B:** Reducing the risk of suicidal behaviour among high risk groups and vulnerable people.
- **Level C:** Responding to suicide

The Hardiker Model: is a framework for describing and positioning the range of universal and targeted support services. The Hardiker model of assessment is based upon the assumption that service users lie upon a continuum of needs. The model is further based on the principle that there needs to be access to a continuum of services for all, appropriate to the assessed level of need.

The Hardiker model provided valuable guidance that assisted the research team in a clear description and positioning of services being offered in areas of prevention, intervention and postvention. This further permitted the researchers to review local provision and subsequently to consider said provision as part of a continuum of need. The Hardiker model is described using the levels as outlined



1. Universal (Level 1)

The Hardiker model underpins the provision of universal services to all. The services identified as universal are such services as schools, mental health and health provision i.e. GP, hospitals, available to all as they are required. The needs of those in the community are appropriately met within this framework.

2. Vulnerable (Level 2)

Level 2 includes vulnerable groups of people who have been assessed as having additional needs which cannot be provided for purely by universal provision. These needs may be met by an additional piece of support by one agency or may be a number working together to address the identified needs.

We must not lose sight of the reality that universal provision is part of the overall plan. Targeted work includes programmes, activities and work where people are referred due to falling into a certain category of condition, educational attainment or behaviour. The types of work offered by respondents and considered targeted work by the researchers, include drug use/alcohol education programmes, lower risk offending and anti-social behaviour programmes, parenting and Lesbian, Gay and bi-sexual education programmes, disadvantaged and/or education/participation programmes.

3. Complex (Level 3) Of those people with additional needs there may be a proportion that has more significant or complex issues, some of whom would meet the threshold for statutory involvement. This group is often referred to as complex in need. The “complex” in need group includes those for whom there are risk and protection concerns. This group has a range of needs that require the co-ordination of a range of services including some specialised.

4. Severe (Level 4) Of those people who have complex needs there will be a small proportion that have acute needs. This group will include looked after children/adults (in residential care), those with severe and complex special needs, people with complex disabilities or complex health needs. This group will also include people diagnosed with significant mental health problems and offenders involved with the community and custodial Justice System.

Clear Project Standards: The CLEAR Project: Service Standards and Quality Assessment Framework for Community Voluntary Sector organisations in Northern Ireland define levels of support in the following way:

Tier 1 – universal services aimed at the general population

Tier 2 – early intervention providing supportive environments for generally targeted groups and those at risk

Tier 3 – intensive intervention for more severe or complex issues providing specialist services

Tier 4 – acute treatment providing very specialist services such as day units.

The questionnaire, in using the terms “*suicide prevention*”, suicide intervention and postvention, defined the terms as follows:

Suicide prevention: the science and practice of identifying and reducing the impact of risk factors associated with suicidal behaviour and of identifying and promoting factors that protect against engaging in suicidal behaviour. (Reach Out: 2005:9)

Suicide Intervention: an immediate, short-term, psychotherapeutic and/or other service which as the aim to resolve a personal crisis within the immediate environment of an individual/family/group.

Suicide Postvention: provision of crisis intervention, support and assistance for those affected by a completed suicide (American Association of Suicidology).

Using the, Reach Out: Irish National Strategy for Action on Suicide, the organisations were requested to define the levels of action and current focus and activity of the organisation. The purpose of the question was to ascertain the range of activities within organisations responding to the questionnaire. The responses indicated the following:

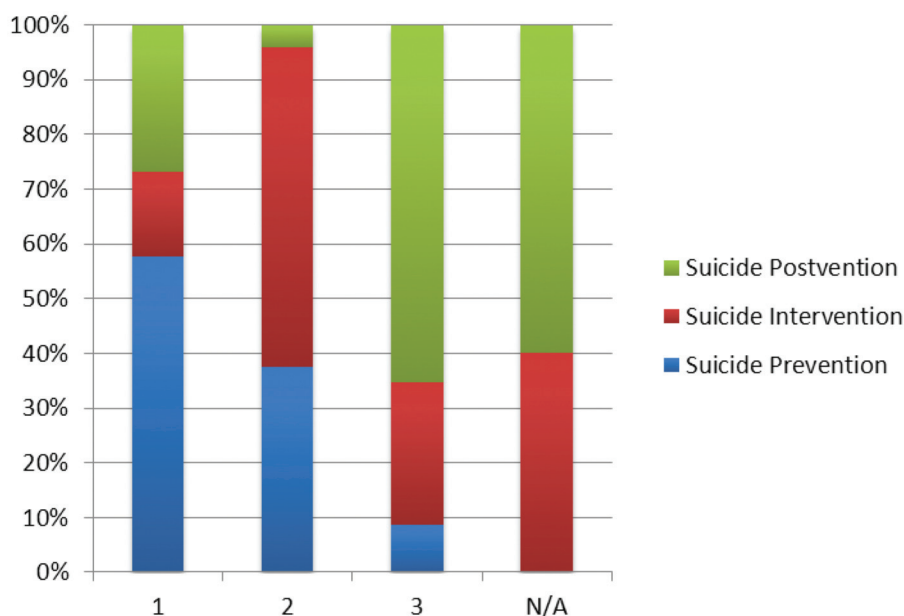
5:6. Findings

Informing the focus of activity

Rank the following in order of the current focus of the organisation’s activities

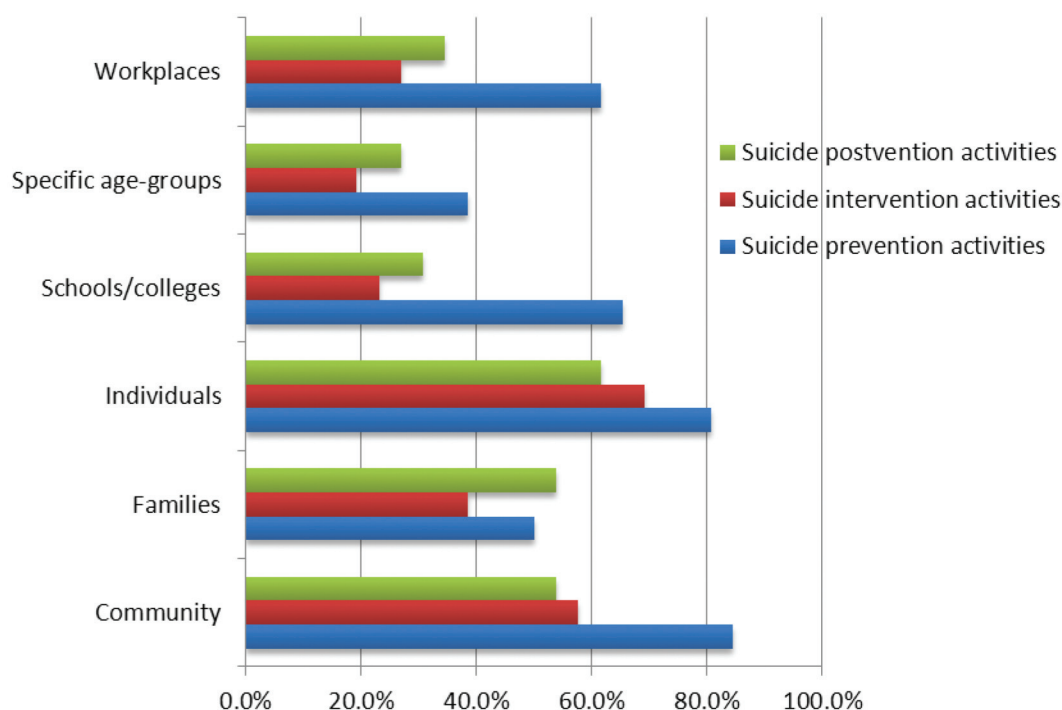
1 = organisation focuses most on this activity

3 = organisation focuses least on this activity



This table demonstrates that almost all of the organisations from their self report appear to be offering services above and beyond their stated service objective; the authors posit the opinion that it is not as simplistic as placing organisations within one sphere of demarcated practice when the research clearly indicates that whilst there is a primary level of practice determined by attachment to post/pre or intervention their practice overlaps all of the above.

Which of the following groups do the organizations work with across its activities?



The data clearly indicates that for some organisations the work falls into a number of categories: Prevention, Intervention and postvention and with a wide range of groups ranging from general population, targeted and that in crisis. The authors observe that whilst there are stated and strategic primary activities and practices within the focus of each

organisation that focus widens and the data demonstrates that the focus of the organisations respond to more than one stated need, group or setting.

Which of the following age-groups does the organisation work with across its activities?

| | Suicide prevention activities | Suicide intervention activities | Suicide postvention activities |
|-------------------|-------------------------------|---------------------------------|--------------------------------|
| 0 - 5 year olds | 3.8% (1) | 0% (0) | 11.5% (3) |
| 6 - 10 year olds | 15.4% (4) | 7.7% (2) | 19.2% (5) |
| 11 - 18 year olds | 61.5% (16) | 50% (13) | 46.2% (12) |
| 19 - 25 year olds | 92.3% (24) | 69.2% (18) | 57.7% (15) |
| 26 - 50 year olds | 88.5% (23) | 69.2% (18) | 53.8% (14) |
| 51 - 64 year olds | 84.6% (22) | 69.2% (18) | 53.8% (14) |
| Those aged 65+ | 73.1% (19) | 57.7% (15) | 53.8% (14) |

The research clearly indicates that the highest risk category where most of the focus of organisations work is occurring coalesces around the 19-25 yr. old age range. The authors further observe the high percentage of organisations working across age ranges and particularly highlight the very real need to consider the specific and particular skill sets, training and CPD needs arising from and particular to practice effectively and safely across such a wide and varied range of age groups.

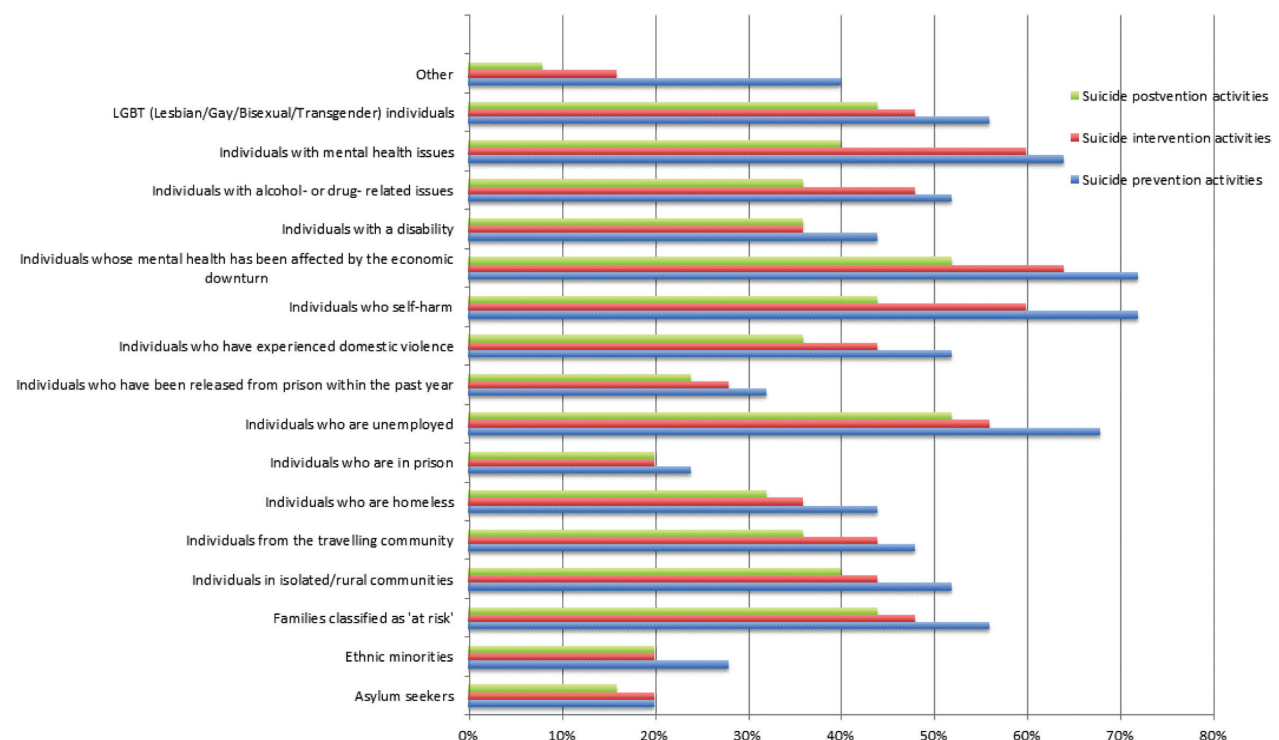
Question 14: Prevention and Promoting positive mental health

Questions 14 and 15 logically weave into each other and consider prevention, promotion intervention and the targeting of services.

Organisations were requested to identify the targeted groups with which they worked. The data indicated that the majority of work is conducted with the following groupings. It is noted that the preventative work/support service described by respondents indicates a very wide ranging category.

Organisations were asked to indicate the high risk groups they work with when carrying out prevention and/or intervention activities. The definition and list of those defined as higher risk is derived from Reach Out and included the following:

Which of the following types of service-user does the organization work with across its activities?



As the data above indicates a high percentage of organisations report that they deal with more than one need area, and appear to offer services to address the needs of a wide range of high risk and/or vulnerable individuals and groups. It appears that a high percentage of the organisations offer services which address a wide range of universal, targeted and specialist needs with a diverse number of client groups and particular needs.

In the suicide prevention and intervention sector what emerges in the questionnaire results is that the focus of prevention services and intervention services primarily revolves around mental health and well-being. Support and counselling services appear to be generic and offering approaches addressing a number of needs, rather than specifically focussed in the specialist area of suicide prevention/intervention.

The major areas identified in terms of services offered and provided are as follows.

1. **Individuals affected by the economic downturn 72%**
2. **Individuals who self-harm 72%**
3. **Individuals who are unemployed 68%**

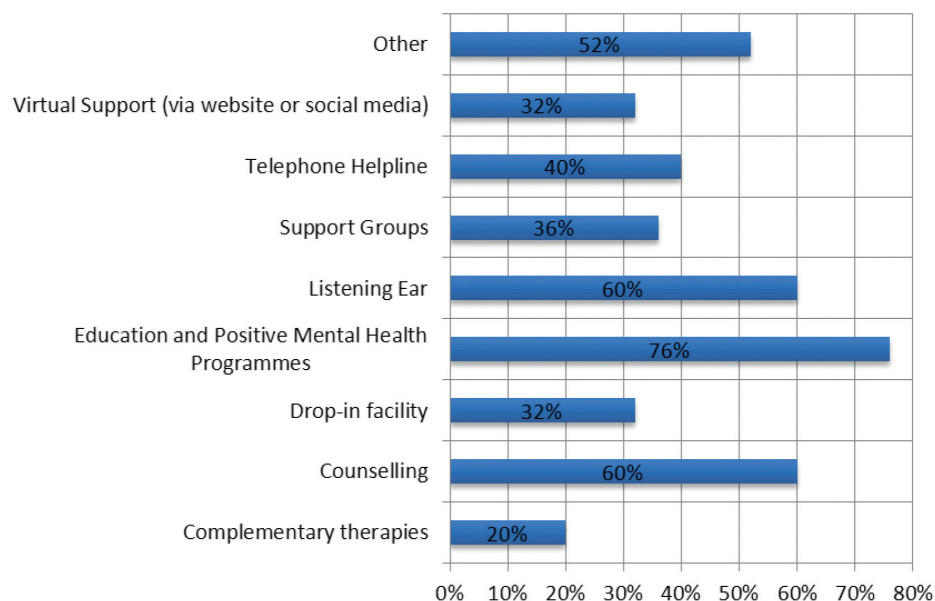
At the lower end of the spectrum of services offered and provided the following emerged.

1. **Ethnic Minorities 28%**
2. **Individuals in Prison 24%**
3. **Asylum Seekers 20%**

Where other was indicated in response to the question this specifically referred to and included those in psychiatric care, armed forces, individuals and groups within the community who sought the services of organisations in the provision of training for people working either professionally or voluntarily with young people at risk.

The authors note that 57.7% (15) of organisations stated that they offer particular services defined as postvention support and counselling. Of those, two organisations are established with a particular focus on suicide bereavement services. It emerges that a number of additional organisations offer support to a range of groups and individuals as a result of suicide in the community. Of this group postvention services are offered in communities, schools and work-places with a range of individuals and age range of service user.

Which of the following services does the organisation offer?



Answered Question = 25

Skipped Question = 1

It is evident that the organisations surveyed provide a range of services, with some stating that they provide a number of different types of services using a range of methods of intervention and delivery. The services offered are as follows and range from drop in facilities, listening ear, alternative therapies, education and programmes through to counselling.

Support Services, Positive Mental Health and Prevention:

The highest percentage of work appears to be support services. This includes a wide range of activities and can range from information and awareness, leaflets, alternative therapies and group support. It is difficult to calculate and articulate the levels of support offered to individuals, groups and communities through the questionnaire methodology. It is evident that a number of local organisations offer a support response to those in crisis and that effort and activity may remain uncalculated and undocumented. This is an area for attention in developing an accreditation model that enables mapping and articulation of activities at local, regional and national level.

"I think that the survey does not reflect the work that a vast number of organisations engage in i.e. provision of support. I would recommend a separate set of questions more relevant to voluntary support services." (Interviewee)

For the authors it is important to consider how organisations define their areas of practice. The research considered prevention services to include support and well being practices carried out by organisations. The distinction between well-being, support services, postvention support strategies appears to be unclear.

If you indicated in the previous question that the organisation offers a counselling service, please tick below to show the types of counselling which are offered.

| | Count | Percent |
|-------------|-------|---------|
| Bereavement | 8 | 47.10% |
| Group | 6 | 35.30% |
| Individual | 14 | 82.40% |
| Other | 5 | 29.40% |

Examples of Activity as specified by respondents.

- Could be group activity if applicable vis suitability of client
- Couple
- Family
- Mentoring

"We provide bereavement support across the life span to individuals, groups, families, children, and young people. All personnel are trained to the highest standard."

Answered Question = 17 ; Skipped Question = 9

Question 18: Promoting Services

Which of the following does the organisation use to promote its services?

| | Count | Percent |
|--|-------|---------|
| Advertising (newspapers / magazines) | 14 | 56% |
| Advertising (on the radio) | 11 | 44% |
| Editorials (i.e. Articles in newspapers/magazines) | 13 | 52% |
| Facebook | 16 | 64% |
| Printed material such as leaflets | 22 | 88% |
| Website | 15 | 60% |
| Other | 11 | 44% |

Promotion and marketing of suicide prevention, intervention and postvention services by organisations requires expertise, resources and skills. In particular, smaller groups indicate difficulty in developing effective marketing and advertising resources. The authors acknowledge that the Services on offer are advertised and promoted using a range of methods and strategies including printed media, leaflets and newspapers, radio, Facebook and social networking,

websites and other methods as defined by respondents

The data indicates that web based and new technologies with printed materials form the greatest percentage of resources. The relationship between the organisations and local print media and local radio has proved to be a valuable resource to smaller local and community groups who seek to improve awareness

44% of respondents stated that their advertising and marketing fell into the other category and these are presented within the list below.

As observed by one group

"We produce our own magazine which is delivered to 7000 homes in the area as well as all services, hostels, halting sites, prisons, hospitals, GP's and public venues utilised by people from area. We also produce and distribute materials to coincide with campaigns and use different media depending on the campaign e.g. bus stop posters, webpages, social media, radio ads, promotional material through pubs, off licences, GP's etc."

Whilst another stated,

"We are currently working on the development of our website." It is timely to remind ourselves that this demonstrates a number of the innovative approaches employed by various organisations to market suicide prevention services.

Other

- Direct marketing to other agencies, mental health services, GP's for example
- Distribution of local suicide emergency telephone number during monthly 'street walks'. Monthly text broadcast.
- Network meetings
- Send to other organisations working in mental health and suicide prevention
- Social media; word of mouth; health professionals;
- Sponsor local soccer and GAA clubs jerseys and pitches
- TV programmes /radio interviews
- via GPs and Consultants

Answered Question = 25

Skipped Question = 1

Q. How many of the following types of staff are employed by the organisation?

| | Paid employees (full-time) | Paid employees (part-time) | Volunteers |
|-------|----------------------------|----------------------------|------------|
| 0 | 44% (11) | 48% (12) | 8% (2) |
| 1-2 | 28% (7) | 16% (4) | 8% (2) |
| 3-5 | 12% (3) | 12% (3) | 4% (1) |
| 6-10 | 4% (1) | 12% (3) | 20% (5) |
| 11-20 | 8% (2) | 4% (1) | 20% (5) |
| 21-50 | 4% (1) | 8% (2) | 12% (3) |
| 51+ | 0% (0) | 0% (0) | 28% (7) |

Answered Question = 25

Skipped Question = 1

Q. Does the organisation employ counsellors (paid or voluntary)?

| | Count | Percent |
|-----|-------|---------|
| Yes | 14 | 56% |
| No | 11 | 44% |

Answered Question = 25

Skipped Question = 1

It should be noted that some responses to this and subsequent questions that respondents highlighted variations in definitions of employ and hiring in. As observed by one organisation,

"There is an assumption that this company 'employ'. We do not and only 'hire' existing services. Please note as this research does not cover this area at all and could be misleading". (Interviewee)

The question of hiring in, as it refers to sessional workers, is in fact addressed in the following question and from this, greater detail and inference can be drawn in relation to accuracy of employment of fulltime, part-time staff and volunteers in terms of service provision and day to day administration of the organisations who responded.

The above table indicates that all organisations make use of volunteers but in some cases as the table indicates organisations appear to rely more heavily upon small numbers of full or part time employees (on average less than five) with volunteers carrying out many of the core duties. The majority of groups 56% make use of paid or voluntary counsellors within their services.

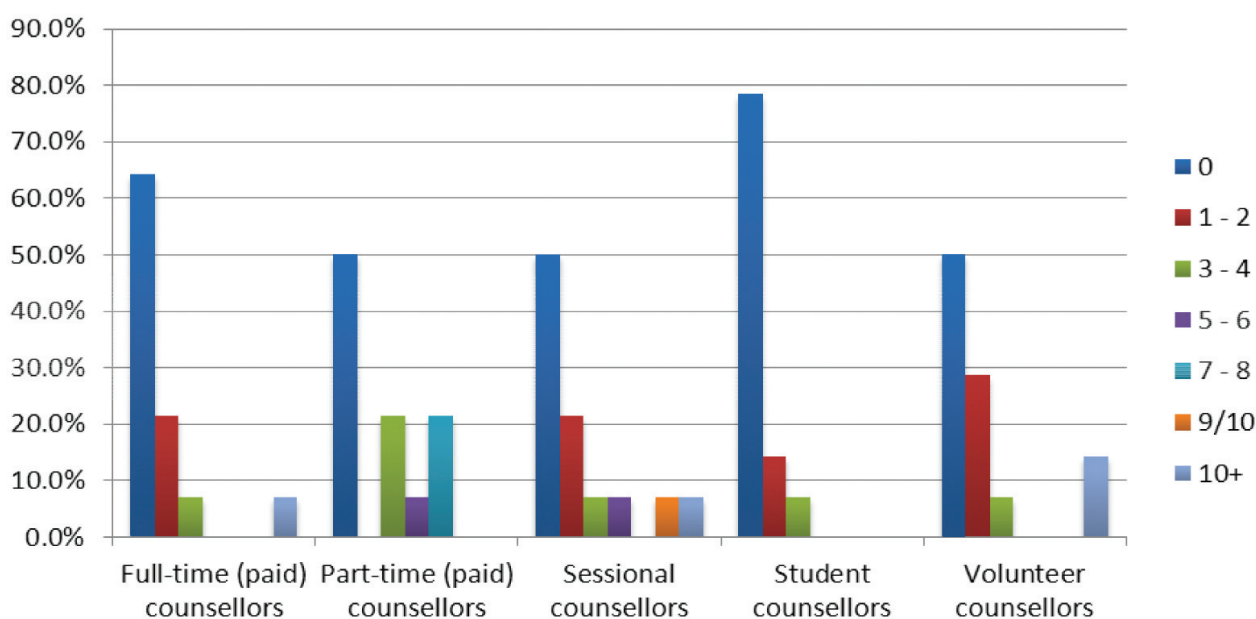
Qualification and Employment:

The following tables indicate the responses from organisations centring on the support and counselling services offered as can be seen from the resultant material offered. The greater number of organisations does not necessarily employ fulltime staff but heavily rely upon a mix of part time, sessional, student and volunteer's counsellors. 92% of respondents require a minimum qualification with the lowest level an undergraduate diploma with respondents stating that a range of qualifications inclusive of degree, post graduate and masters level being found acceptable to organisations.

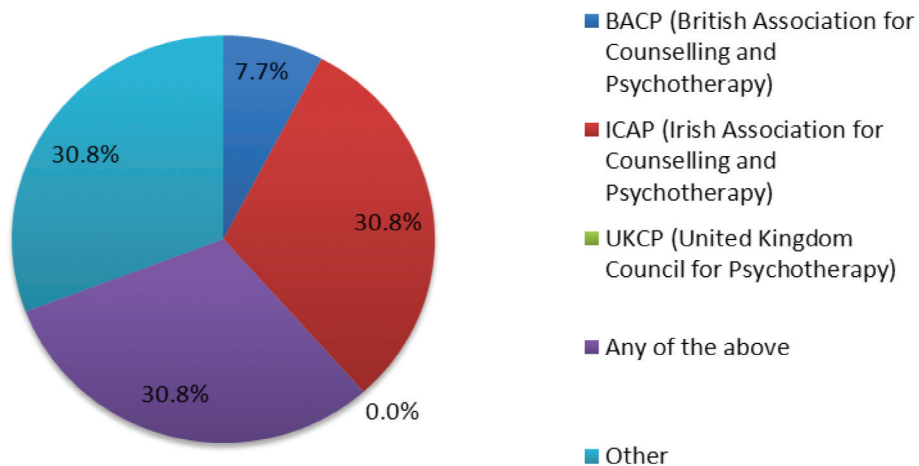
Professional accreditation appears to be a universal requirement with a number of counselling and psychotherapy accrediting bodies being deemed acceptable for practice within the organisations.

The scale of qualification can affect the level of particular service and ability to offer such a service across the sector. This can impact either positively or negatively dependant on the organisations level of governance, supervision and support affecting and impacting on the practice of the same.

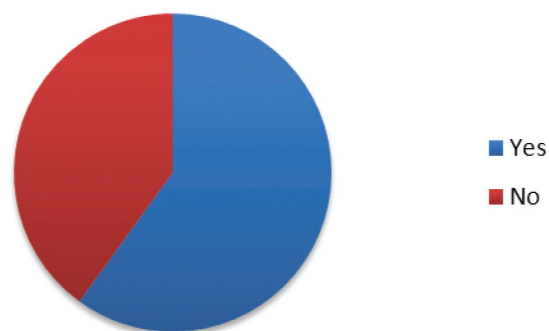
How many counsellors does the organisation employ?



Which professional accreditation does the organisation require counsellors to hold/be working towards?

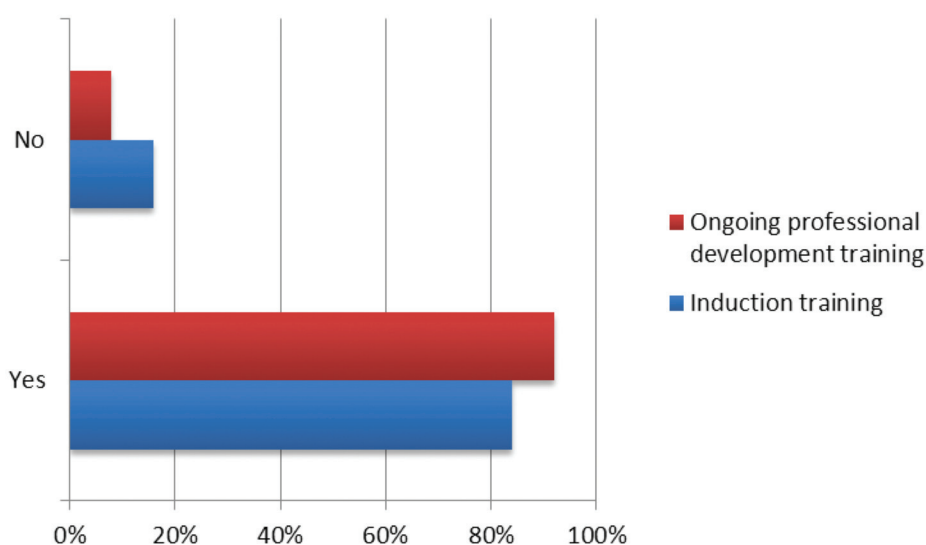


Are all staff (including volunteers) required to undergo Access NI checks / Garda Clearance?

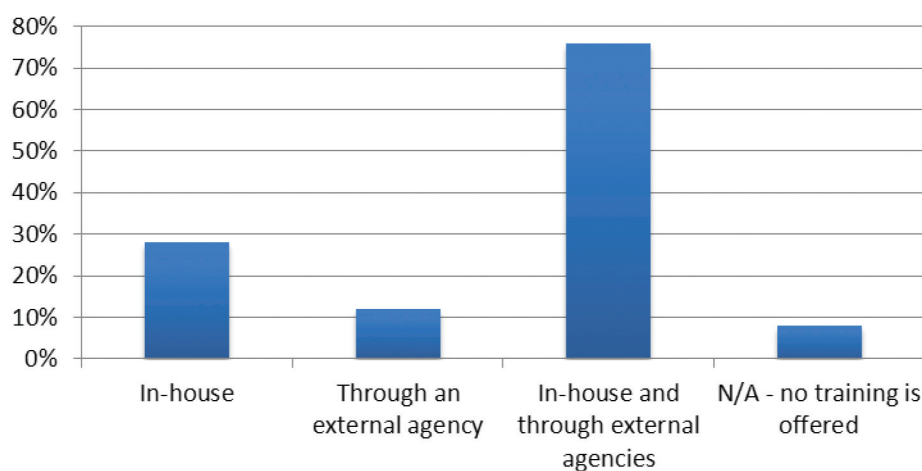


Garda /PSNI clearance, from the author's perspective should be a nominal prerequisite for all organisations and practitioners in this field.

Does the organisation offer training to staff (including volunteers)?



How is the training offered?



5.7. Conclusions

The development of an accreditation model for the voluntary suicide prevention, postvention and intervention sector in Ireland has been discussed since the publication of the National Task Force Review Group on Suicide in 1998. The foundation of Reach Out a National Strategy for Action on Suicide Prevention 2005-2014 includes the guiding principles, as *"action focussed, practical, achievable, regular evaluation, broad based and evidence based"* (IAS Newsletter: 2011). This initiative has the support of the participants of this research process. Those who responded to the quantitative survey, were interviewed as part of the qualitative phase of research and participated in the expert group consultation process expressed a strong desire to see an accreditation model and quality systems developed for the sector. The researchers note the importance of ensuring a careful and determined assessment of all the vital and important themes emerging from the consultation exercise that seek to inform recommendations, require clarification and be embedded within such a model.

This review of findings will consider the information derived from the consultation process and will address from a number of perspectives. It is evident that an effective evaluation and accreditation models can be devised but the authors are clear that in developing such a model we must take account of the “process” for organisations and individuals within them. It is important to develop a strategy that considers and ensures minimum adverse impact on staff, one which ensures skills and confidence for those managing change within organisations, generates a high level of involvement from the suicide prevention sector and that effective communication takes place.

The evaluation of findings and themes within the research will be considered using The Logic Model and specifically, as stated previously in this research, Paul McCawley’s (University of Idaho) guidelines on reflection within the Logic Model.

7. *What is the current situation that we intend to impact?*
8. *What behaviours/practice needs to change for that outcome to achieve?*
9. *What knowledge or skills do people need before the behaviour/practice will change?*
10. *What activities need to be performed to cause necessary learning?*
11. *What resources will be required to achieve the desired outcome?*
12. *What will it look like when we achieve the desired situation/outcome?*

In seeking the consideration of the structures it was clear that those considerations numbered one through to three overlapped extensively in terms of response by the participants and could effectively be grouped together within our consideration within these pages.

What is the current situation we intend to impact? / What behaviours/practice needs to change for that outcome to achieve? / What knowledge or skills do people need before the behaviour/practice will change?

Within the subsequent section the authors present a number of the shared observations as posited by the various individual and group participants who participated and facilitated this research.

6. Guiding Principles

6.1. Guiding Principles, Ethos and Values

The majority of organisations responding to this research observed that they had clarity of vision and aim for their organisations. There were those who stated that they responded to need and provided services across the three considered levels of prevention, intervention and postvention.

The principles that would determine and guide such a model, it was agreed must ensure a supportive and empowering experience for staff, volunteers and clients and in doing so should have at their foundations a real sense of creative engagement and ownership by all who engage.

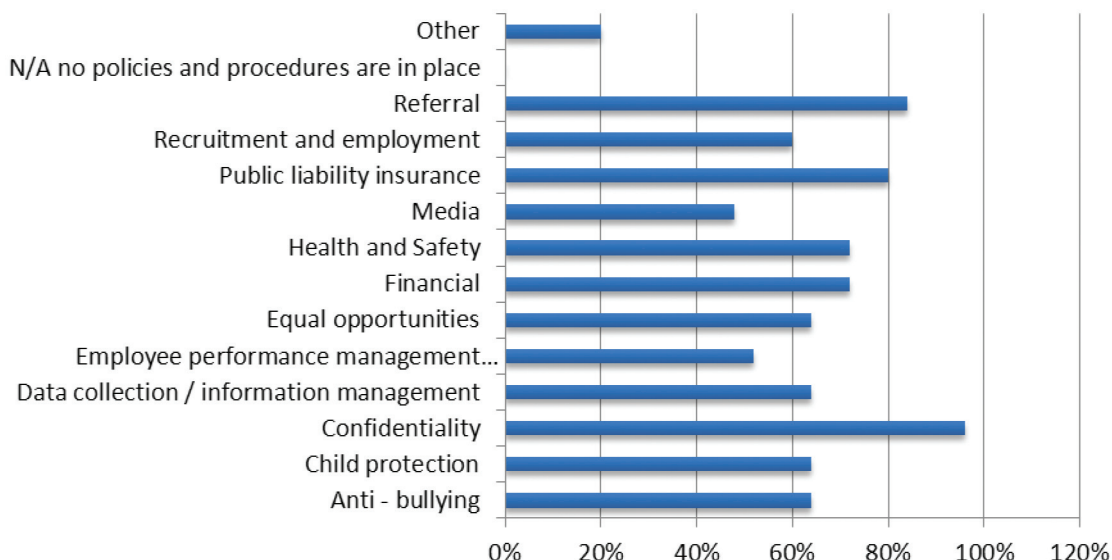
One major consideration related to the fear that a lack of effective mechanisms such as those presented above might lead to less ethical people later replacing current effective practitioners within organisations. Consequently it was felt that there was an inherent responsibility to ensure that any ethical framework considered this, as it has been reported that at times there are those who practice with a lack of ethical consideration of suitable and congruent intervention or recognised boundaries.

The model offers a number of guiding principles that are recommended for all organisations engaging in the accreditation process. Such principles must actively consider the overall ethos and vision of the organisation, its code of ethics and practice that includes an understanding of good boundaries and self-care. Essential to such a consideration is that it be actively informed by the rights and responsibilities to and for the client within a person centred approach to pre/post and intervention practices.

6:2. Governance and Structure

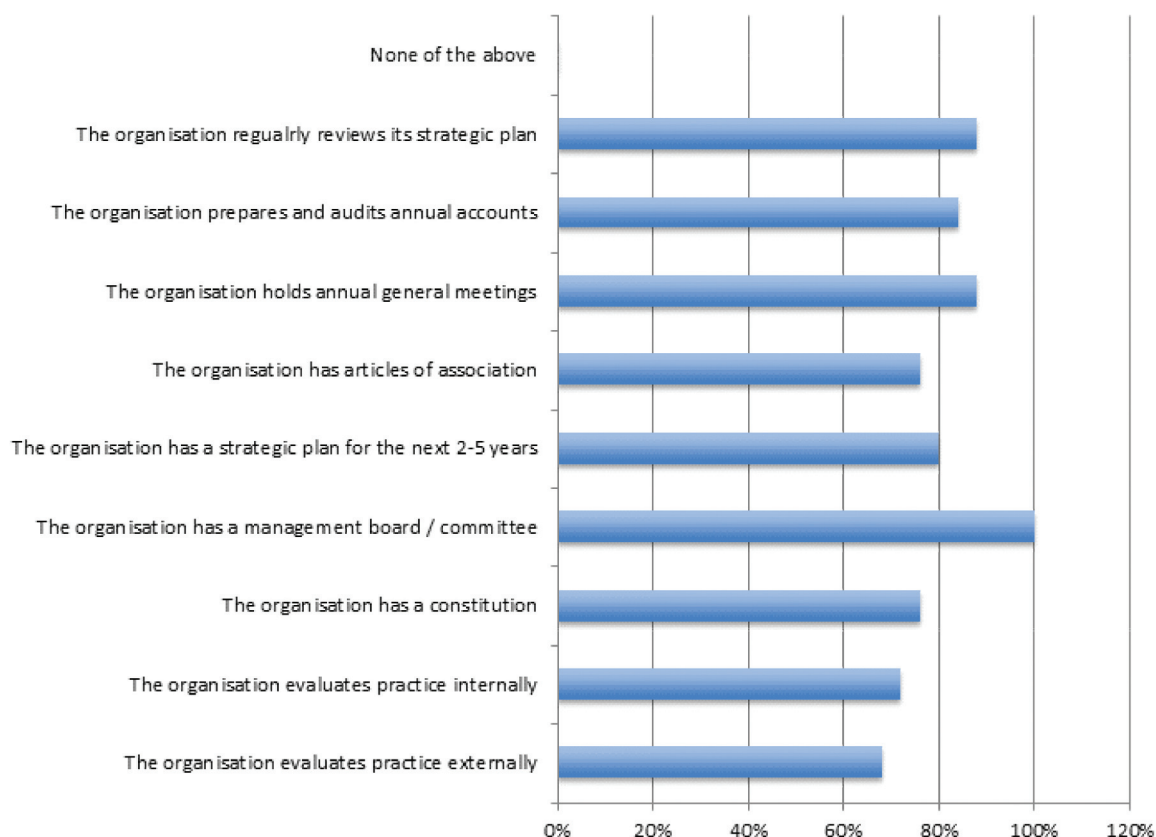
There are a variety of different structure systems used for the development of organisations within the voluntary suicide prevention, postvention and intervention sector in Ireland. They range in complexity linked to the size of the organisation. On the whole the subsequent table illustrates a robust and positive adherence to policy, procedure and good governance practice.

Which of these policies and procedures does the organisation have in place?



Those larger organisations have corporate structures, and directors with board of directors. There are regional organisations which have overall directors and smaller organisation which may have one employee to those staffed entirely by volunteers.

Tick the statements that apply



As indicated above there is a range of quality assurance practices and models appear to be in place depending on the structure of the organisation. A number of national organisations and larger regional groups adhere to/engage with PQASSO, CORE evaluation systems, ISO: 9001:2000 Quality Management Standards. A diverse level of organisational accreditation and quality management systems are in place within the sector.

In considering this central theme the authors took into active consideration the fears, expectations and anxieties of the participants who observed and cautioned that they would be very fearful should the level of paperwork or governance become too onerous that the organisation could go under as the members may not be able to devote extra time to excessive administration practices and procedures that may ultimately eclipse the practices and programmes offered by them for pre/post and intervention.

With this in mind the authors, are aware that the model includes appropriate and required levels of accreditation that correspond to the size and resources of organisations that undertake the process.

From their experience the respondents observed that each group should have stated aims and objectives. Consequently each group should have defined roles for each of their members with audited records of all financial transactions and how funding and resources were spent. For those who participated, there was a general agreement that fundamental to this was a belief that organisations develop a clarity around their vision and direction, remit and responsibility of-fering a definition of its role and its limitation of practice within the field.

The recommended model of accreditation should have a foundation level of essential governance and structure which must be adhered to for all organisations.

6:3. Qualifications

There is a belief that any organisations involved in suicide intervention, prevention, postvention should be suitably qualified for the services they offer. Whilst respondents could not specify what minimum qualifications should be required for people in organisations in the sector it was deemed essential that all staff and volunteers be suitably qualified in terms of practice and engagement.

The accreditation model will consider and recommend a level of minimum qualification suitable to basic practice and intervention.

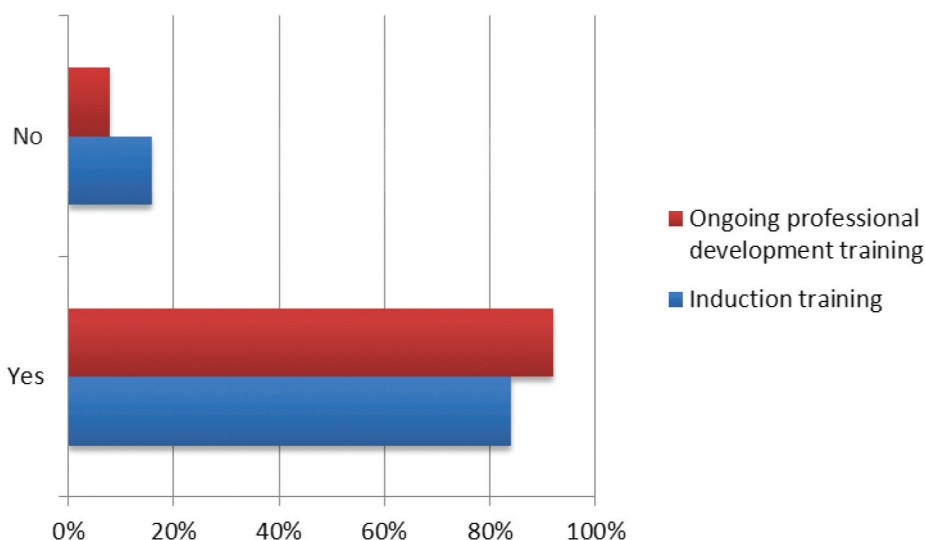
6:4. Inspection

There was a general consensus that all organisations should be audited and inspected as part of the accreditation process. The management and organisation of such a procedure requires further consideration of any implementation strategy.

The accreditation model will consider and recommend an inspection procedure.

6:5. Training and Development

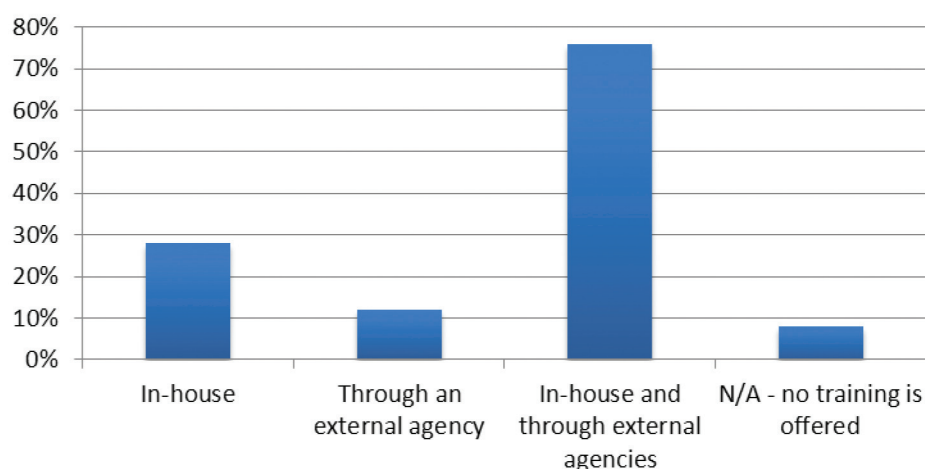
The question was posed, do you offer Training and the following table illustrates the responses offered.



Training was perceived as essential and that any training developed with practice and was on-going and informed by the processes and projects of organisations. There was a firm belief in continuous professional development as a central plank to the organisations awareness and practice. Further to this it was suggested that workers and volunteers need to have time to reflect in order to ensure that they continue to have clear boundaries in relation to listening. This could also be done in a peer group capacity.

Other suggestions from respondents included the desire for regular membership conference/seminars and events. It was suggested that a level of generic training re: Listening, Signposting/Referral etc. should be provided free of charge by the statutory sector and this would entitle participating organisations to a 'quality mark' in terms of minimum standards of quality. It was a stated belief that on-going research should be encouraged at all levels. This would, it was argued and support evidence informed and evaluated practice.

How is the training offered?



Training such as ASIST, it was observed, should have adequate follow up with those who have participated in basis training forming peer support groups and being offered refresher training courses. This was considered important for support and professional development.

Linked to the idea of seminars and conferences it was felt that organisations should be encouraged to go beyond the minimum standards required for accreditation. This might include providing workshops (provided by adequately trained facilitators) on the wider range of issues contributing to suicide, such as relationship breakdown, drugs and alcohol abuse, sexuality issues etc.

The research recognises that for some of those engaging in volunteer work within organisations, the desire for on-going training and continuous professional development may be minimal. The organisations focus may be guided by the requirements of the **Good Samaritans and Volunteer Act (2011)**. The limitations and the guidelines for “Good Samaritans” and volunteers in Ireland are guided by legislation in relations to certain activities.

It is acknowledged that organisations to be accredited should be supported to meet the required standards. This may be particularly important for smaller groups and the accreditation process will include training. Training needs cited by respondents during interview included:

- Training in governance and models of good practice
- Volunteer training
- Committee and policy development
- Fundraising and pathways to funding opportunities

The recommended model of accreditation will contain elements that address training and continuous professional development as prerequisites to practice.

6:6. Collaboration and Strategic Planning:

A core response from those interviewed viewed collaboration as an essential consideration to shared and effective practice and resourcing for the sector.

Collaboration facilitates awareness of good practice in other organisation and opens the possibility of a partnership approach between groups. This can lead to a more effective use of resources and avoidance of duplication. Small organisations providing local services would benefit greatly from an agreed and considered linking in to other networks. It was stated that part of the accreditation process *must* centre on the practice of networking. This requires a real willingness to put the needs of the client-base at the core of the organisation. Specific comments refer to collaboration and improved communication or networking through:

- Training in specific skills/themes
- Conference opportunities
- Cross border and European conferences

- Showcase opportunities linked to programmes and strategies around prevention/intervention/postvention
- Research opportunities and support for practice based research

A number of respondents felt strongly, that funding in the sector should only be allocated if groups can demonstrate the principles of real partnership and collaboration. Acknowledgement and recognition of valuable community based service provision was deemed essential in the light that these groups are familiar with the local community infrastructure and dynamics. Such Groups with a small local base have a crucial role to play and it was felt by a number of respondents that such community knowledge is sometimes lacking from the statutory sector and as a result, more cross-sector cooperation is necessary. It was observed by a number of respondents that it is important for national and regional organisations to recognise the role and knowledge of local groups in specific geographic areas.

The recommended model of accreditation will contain elements that address the requirement for a collaborative and partnership approach to working which considers cross sector, thematic and geographic collaborative approaches.

6:7. Funding and Accreditation

There was a sense among respondents that funding from state bodies should be restricted to organisations that have received a particular quality mark in accreditation and that their records and practices should be examined on a periodic basis. Having said that, it was felt that for the smaller organisations, if they had to be accredited that they should be supported both financially and training wise to attain the level they need to get to, to achieve and sustain accreditation status.

The implementation and management of the accreditation model may wish to examine a direct relationship between funding for organisations and engagement with the accreditation process.

6:8. Managing and Marketing Accreditation

Accreditation and the standards it presents need to be adequately publicised in order that people requiring services can make informed choices. Respondents considered that a coordinated approach to the work ought to be based upon an all-Ireland approach as groups would have the very real opportunity to learn from each other. It was observed that Service providers would benefit from reaching out to other countries who are further ahead developmentally speaking in terms of practice with the example given being that of Finland and its emerging practices issues. Membership in an all-Ireland model, which would provide 'kite mark' status to local organisations, would be beneficial.

It was felt by respondents that it was not enough to develop quality standards – they need to be implemented and a commitment given to this at the highest level. A Statutory Commission on Suicide Prevention, a number suggested, could help to standardise provision and regulate service providers.

The recommended model of accreditation will require an implementation and marketing strategy to support and encourage engagement by organisations at national, regional and local level and across organisation in the statutory/voluntary sector who are involved in suicide prevention, intervention and postvention.

6:9. Communication

Regular email updates on emerging developments and practical responses in the field, from the head organisation, would be useful. The quality mark standard would allow the organisation to be recognised by the Irish Association of Suicidology (IAS). The development of a communication "hub" is recommended, to include the aforementioned database and an *"e pipe (electronic communication)"* system of ensuring up to date links and communication of all services, training, volunteering, employment, funding possibilities and events.

In terms of marketing and awareness outside of the sector the view was voiced by a number of respondents that there is a huge challenge in the field to develop more general/generic awareness of issues of suicide and self-harm, for example, along the lines of Stroke and Cancer awareness. If this occurred successfully it was felt that it would go a long way towards removing the stigma.

That, with regard to all National initiatives that there be a sustained and consistent level of communication and information to ensure that awareness of the initiative is offered within a clear and understandable structure and framework

for and to all organisations and groups. In this way, it was argued, we can all sing off the same hymn sheet.

It was agreed that an effective resource would be the placement of all groups who attain kite mark status in a local/regional/national directory that would be widely available in doctor's surgeries and other prominent public locations.

The research accreditation model recommends the development of a communication strategy to support the suicide prevention/intervention and postvention sector. Such a communication strategy must be linked to strategic planning and collaboration policies of organisations.

6:10. Information Management and Data Collection

Data collection, information gathering, the collation of national regional and local statistics about prevention, intervention and postvention activities is clearly a central theme and concern for the respondents. Data about the activities of organisations across the sector is not collated and thus a clear picture of the practices and processes is unavailable to those involved in post, pre and intervention work. At a central, national, local and regional level it is useful to explore the communication and information sharing between funding organisations where data and statistics about prevention, intervention and postvention services is collected as part of funding strategies.

Data collection and statistic management and the collation of findings pertinent to overall practice were identified as a central theme to good practice. Respondents identified the need for such a resource and data base to be collated and managed by an identified central governing authority or body that consequently could adapt the information to inform the distribution of vital limited resources.

The relationship between data collection/statistic management to evidence informed/evidence based practice is highlighted during interview. Evaluation practices and the gathering of evidence to inform strategies and practice development vary between organisations of differing sizes and with varying degrees of organisation.

6:11. Resources

The interviews asked respondents about current resources and the implications of accreditation process on resource strategies. It is evident that fundraising and funding applications and developing income sources is a demanding, time consuming and difficult issue, particularly for smaller organisations. There is limited evidence that funding of a long term funding nature is available in the sector, medium term (2-3 year) sources appear to exist for some groups and the majority of organisations rely on short term sources and donations.

Respondents expressed concern about possible resource implication arising from accreditation and felt that additional funding would be required to meet the needs of accreditation. Particular concerns expressed included potential financial cost of engaging in the process, possible training, staff development and administrative costs anticipated by accreditation. Particular to smaller and more local groups, who rely on volunteer, is the possible time and expertise required to enable organisations to engage and meet the requirements of the accreditation model.

The research accreditation model recommends that resourcing toward the development and implementation of accreditation must be addressed to support and sustain the suicide prevention/intervention and postvention voluntary sector.

7. Introduction to the Model

It is essential in developing any model of accreditation that it is formed around the highest guiding principles and values that should inform and determine the direction and emphasis of the model. Such principles and values must be at all times in a process of considered development and rooted in a shared ethical base of reflection and practice.

Such values and principles must be open to an on-going process of being formed and shaped by the experiences and feedback of staff and service users. It must be considered as an open ended and vital practice to any engagement by those working in the field of practice.

For the authors this foundation holds a primacy rooted in the development of any model of accreditation for those organisations and practitioners in the area of Pre/Inter and Postvention practices in the area of suicide awareness practice.

There is a real need for fundamental guiding principles that permit a challenge to openness and partnership nationally, regionally and locally in a transparency of reflective practice and achievements.

In our consideration of the above the authors were impressed and guided by the Clinic for Professional Boundaries Studies and that studies breakdown of their code of ethics. This code too emphasises the need for transparency and coherent, consistent practice of evaluation based upon values, principles and behaviours. We present their reflections for your active consideration.

- **Values** are the enduring ideals on which our organisation is based.
- **Principles** are informed by our values but are more action orientated; they link our values to our rules. They are designed to encourage practitioners to become autonomous ethical decision makers within the framework of the code.
- **Rules** draw attention to areas of practice that are commonly noted by clients with regard to negative experiences.

Clinic for Professional Boundaries Studies(2012)

With this in mind the authors are encouraged to propose that organisations undertake a very real process of regular review that considers their own values, principles and rules and that this occur prior to any engagement with the accreditation process. As observed by the study the authors share the belief that such a review be dynamic and considered as alive in that it grows and develops, informed by the practice and the experiences of both service users and staff, which are continuous and on-going.

7:1. In Considering Core Values

Organisations should regularly consider those core values that guide their practice; what are they, how did they form, how do they inform current practice? Are they still relevant to the ideal and practice of the organisation?

The questions can be phrased and considered in the following way.

1. What are the visions and the ideal upon which the organisation is based?
2. Is the organisations purpose clear?
3. Has the organisation considered and acknowledged the limit of their influence, scope and the boundaries of their practice?

7.2. In Considering Principles

1. What does the organisation consider are their core principles of practice?
2. What do they consider holds the primacy of importance in informing their practice?
 - The clients and community wellbeing within which the organisation engages?
 - The organisation protects the privacy of the client/ community.
 - The organisation protects the dignity of the client/community.
 - The organisation is accountable for its actions.
 - The organisation is committed to a transparency of practices which encapsulates the need to be congruent, open and clear in their responsibility and actions.
 - The organisation is committed to fairness and justice.
 - The organisation works for the wellbeing and with due regard of all clients/ communities within recognised roles and legal and regulatory limits.

7.3. Ethical and Informed Behaviour of Practice and Competence

The authors are of the belief that all organisations hold a responsibility to revisit and review their own codes of ethics to ensure that they are valid and considered within the parameters of their working practice and engagement with the individual and the community in which they serve.

We suggest that such a code should invariably include the following:

- Confidentiality
- Professional competence
- Effective communication
- Self-determination
- Management of Information
- Contracting and Consent
- Adherence to agreed policies and procedures

Linked to all of the above ethics, values and principles the authors are of the opinion that it is evident from our engagement in this research that working within the sphere of suicide prevention, intervention and postvention is at all times intellectually, spiritually, physically, mentally demanding. It is a responsibility for organisations, and all individuals within them, to ensure that there is an awareness of and commitment to clear boundaries of practice and self-care.

We view the following boundaries as essential for consideration within this area.

- **Time, Space and Place Boundaries:** - having a sense of clear boundaries permits us a sense of ourselves. Ensuring we have a clarity of time, time for engagement of practice, time for self, an awareness of the practice of chopping and changing times without consideration of the effect of this practice. Intrusion into our or the others personal space and a lack of the sense of the self and your space within the organisation can create anxiety. Location of services, adequate suitable spaces and places also contribute greatly to the well-being of those working/volunteering in the sector. Particularly with the advent of new technologies where one is accessible on a twenty four hour basis one must ensure a strong degree of self-awareness and self-care.
- **The boundary between the self and other:** this we consider crucial in that, within the sphere of practice covering suicide, there are many who have had experience of personal loss. The capacity to be aware of one's emotional boundary and sense of one's own emotional need is paramount to any practitioner.
- **The boundary between the group and the individual:** this is linked to the boundary immediately above and concerns how those in organisations or groups impact on each other whether negatively or positively. The organisation is not static but dynamic and as such the experience of those within it changes and consequently boundaries also change and impact on all concerned. Attend to the individual and groups self-care to ensure good practice.
- **Ethical Moral and Legal boundaries:** boundaries (*covered above*)

8. STEP

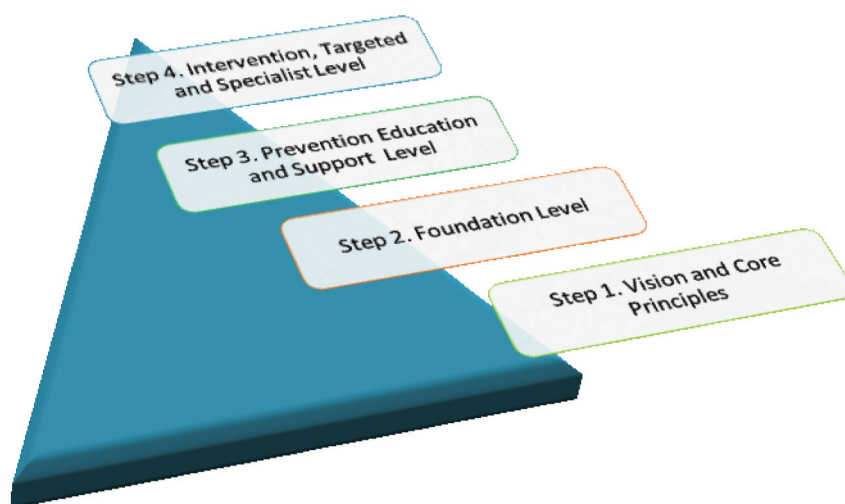
***Model of Accreditation for the Voluntary
Suicide Prevention, Intervention
and Postvention Sector in Ireland.***

Step: Supporting and Affirming Best practice

The STEP model of accreditation is outlined below and is based upon the quantitative and qualitative research findings, examination of international and national literature on accreditation models and exploration of existing models across a number of sectors and professional disciplines. The aim is to ensure that the model recommended for use in the suicide prevention, intervention and postvention sector has clarity of purpose, succinctly captures pertinent and important themes, uses clear language and can be engaged with at a number of levels.

8.1 The STEP Model

The model of accreditation is developed as a layered and “stepped” approach with a foundation level and increasing levels of accreditation linked to the practice of organisations. The model is outlined below:



The accreditation requirements at each step are outlined below.

Each item contained in the STEP Model of accreditation is written as a statement of action or behaviour (e.g. “the organisation has a strategic plan”). Organisations will identify at which step they operate and will clarify the services of the organisation against the matrix of statements of good practice”

8.2 STEP 1. Vision Purpose and Core Principles

The initial stage of engagement with the STEP model of accreditation supports organisations to clarify and review the organisation vision, purpose principles and values. This should inform and determine the direction and emphasis of the organisations requirements within the STEP model.

Name of Organisation: _____

Address: _____

_____ Phone/s: _____

Email: _____ CompletedBy: _____

4. The vision upon which the organisation is based is clear and defined as:

5. The **purpose** of the organisations is to:

6. The organisation works at the following level/s:

Prevention and/or Postvention Education and Support
Intervention and/or Postvention Targeted and Specialist

7. The **aim** of the organisation is clear and is outlined as:

8. The organisation subscribes to core **principles** of practice:

Examples of core principles are outlined below

- The clients and community wellbeing is paramount within which the organisation
- The organisation protects the privacy of the client/ community.
- The organisation protects the dignity of the client/community.
- The organisation is accountable for its actions.
- The organisation is committed to a transparency of practices which encapsulates the need to be congruent, open and clear in their responsibility and actions.
- The organisation is committed to fairness and justice.
- The organisation works for the wellbeing and with due regard of all clients/ communities within recognised roles and legal and regulatory limits.
- The organisation upholds the rights of all people affected by suicide.

8.3 STEP 2: Foundation Level

Following the review of literature and examination of a variety of models and standards of accreditation; and having completed the research with organisations, it is agreed that the first stage of the accreditation process will be completed by **all** organisations and will involve a set of accreditation **themes** covering key **indicators** with the associated **elements**.

Governance is described as the *“system that ensures the fit between the organisations mission and its performance”* (Getting to Grips with Governance: 9). this refers to the management, control and responsibility for the practice and behaviours of the organisation.

Step 2: Foundation Level

| | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Governance – Procedures – Management – Structures | | | | | | |
| Indicator: Governance | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | The organisation adheres to a code of governance. The organisation complies with all legislation as required by statutory requirement. The organisation and personnel ensure no conflict of interest. The organisation is open and transparent and communicates/consults with stakeholders. The organisation has a code of conduct for all staff and volunteers. The organisation has a structured management committee. | | | | | |

Step 2: Foundation Level

| Theme: Governance – Procedures – Management – Structures | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Procedures | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation has clear, effective and equitable employment/volunteer recruitment policies.</p> <p>Management committee meets monthly/regularly as required by constitution.</p> <p>The organisation holds an Annual General Meeting (AGM).</p> <p>The organisation has adequate insurance with appropriate status and cover.</p> <p>The organisation effective systems in place including relevant forms for key activities including e.g.:</p> <ul style="list-style-type: none">• Referral form• Evaluation forms• Expenses• Application and recruitment <p>Others as required</p> | | | | | |

Step 2: Foundation Level

| | | | | | |
|--|--|-------------------------------|--------------|----------------------|-----------|
| Theme: Governance – Procedures – Management – Structures | | | | | |
| Indicator: Policy and procedures | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | |
| <p>The organisation has relevant policies and procedures in place including:</p> <ul style="list-style-type: none"> • Child Protection Policy • Vulnerable Adult Protection • Data Protection and Information Management • Referral Policy • Equal Opportunities Policy • Financial Controls • Suicide & Self-Harm policy • Recruitment & Selection policies • Confidentiality policy • Complaints procedure • Health and Safety policy • Media Policy | | | | | |
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Step 2: Foundation Level

| | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Governance – Procedures – Management – Structures | | | | | | |
| Indicator: Finances | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| Financial systems of the organisation are effective systems ensuring accountability and regular audit. | | | | | | |

Step 2: Foundation Level

| | | | | | |
|---|--|-------------------------------|--------------|----------------------|----------------|
| Theme: Governance – Procedures – Management – Structures | | | | | |
| Indicator: Recruitment Staff/Volunteers | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | |
| | <p>The organisation has a standardised recruitment and selection process in place to ensure the suitability of potential staff and volunteers.</p> <p>The organisation writes clear job descriptions for each role, including the roles carried out by volunteers.</p> <p>The organisation has underpinning human resource principles that include:</p> <ul style="list-style-type: none"> • Respect • Fairness • Equal opportunity • Freedom from discrimination • Freedom from harassment • Adequate resources/facilities to carry out tasks • Support/supervision systems in place | | | | |
| | | | | | Not Applicable |

Step 2: Foundation Level

| | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Governance – Procedures – Management – Structures | | | | | |
| Indicator: Recruitment Staff/Volunteers | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| The organisation has adequate procedures to cover volunteer expenses. | | | | | |
| The organisation has in place supervision and support structures. | | | | | |
| The organisation ensures adequate staff/volunteer training. | | | | | |
| The organisation clearly defines the competencies required for each post, the skills, qualifications, personal attributes and qualities. | | | | | |
| All staff/volunteers are familiar with requirements of The Good Samaritan Act (2011) (R.O.I.) | | | | | |

Step 2: Foundation Level

| | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Governance – Procedures – Management – Structures | | | | | | |
| Indicator: Recruitment Staff/Volunteers | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| All volunteers complete a contract with the organisation which includes: <ul style="list-style-type: none">• Expectations of the volunteer/organisation• Level of commitment• Boundaries of the role• Confidentiality and data protection (limits therein)• Code of conduct• Underpinning principles• Times/nature of duties• Expenses• Training• Supervision• Insurance cover | | | | | | |

Step 2: Foundation Level

| | | | | | |
|---|--|-------------------------------|--------------|----------------------|-----------|
| Theme: Governance – Procedures – Management – Structures | | | | | |
| Indicator: References and Clearance | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | |
| <p>All staff and volunteers are required to submit references to the organisation and these will be checked prior to commencement of activities/work.</p> <p>The organisation ensures Garda/Police clearance is carried out for all staff/volunteers in the organisation.</p> | | | | | |

Step 2: Foundation Level

| Theme: Governance – Procedures – Management – Structures | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Evaluation and Review | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation has a policy and procedure for reporting/managing accidents and/or other untoward/critical incidents.</p> <p>The organisation monitors and evaluates and reviews practice and business against agreed objectives and strategic plan.</p> <p>The practice of the organisation meets standards and regulations in its area of service provision.</p> <p>The organisation provides services which are continuously monitored.</p> <p>There is an evaluation process in place that enables the organisation to assess the effectiveness of the service</p> | | | | | |

Step 2: Foundation Level

| Theme: Collaboration and Partnership | | | | | | |
|--------------------------------------|---|------------------------|--------------|----------------------|-----------|--|
| Indicator: Collaboration | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | |
| | | | | | | |
| | <p>The organisation acknowledges that the client need is at the centre of and informs its services. The organisation collaborates to ensure services effectively and continually meet that need.</p> <p>The organisation ensures effective and open collaboration with key stakeholders in suicide pre/inter and postvention.</p> <p>The organisation works in partnership with all agencies at local/regional and /or national level in the development/expansion of services.</p> <p>The organisation makes use of collaboration and partnership to ensure evidence informed and need based development of effective suicide pre/inter/postvention strategies.</p> <p>The organisation communicates and consults with all existing services prior to developing strategies locally/regionally or nationally.</p> <p>The organisation collaborates, communicates and works in partnership with key agencies in the voluntary and statutory sector.</p> | | | | | |

Step 2: Foundation Level

| Theme: Services – Programmes – Practices | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Planning | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation plans programmes/services to meet the needs of clients/consumers.</p> <p>Clients are involved in all decisions regarding their service and programme of support/treatment.</p> <p>The services of the organisation are accessible to all either nationally, regionally and/or locally.</p> <p>The organisation has clear strategic direction/plan.</p> | | | | | |

Step 2: Foundation Level

| | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Services – Programmes – Practices | | | | | | |
| Indicator: Assessment | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| Organisation staff and volunteers assess a person's needs and if the organisation does not provide the appropriate service refer the client to an alternative service / organisation. The organisation employs assessment methods to assist planning and service development for clients. | | | | | | |

Step 2: Foundation Level

| | | | | | | |
|---|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Services – Programmes – Practices | | | | | | |
| Indicator: Rights and Responsibilities | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| Staff and volunteers in the organisation show respect for difference and diversity. Staff and volunteers understand the rights and responsibilities of service users. The organisation respects the rights of the service user and ensures they are aware of their rights in relation to services they receive. | | | | | | |

Step 2: Foundation Level

| | | | | | | |
|---|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Services – Programmes – Practices | | | | | | |
| Indicator: Data Collection, recording and review | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| The organisation has procedures for collection, collation and audit of services and support, prevention, postvention and intervention activities. | | | | | | |

Step 2: Foundation Level

| Theme: Services – Programmes – Practices | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Recording Information | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation records, stores and maintains information on service users in accordance with the Data Protection Act (1988/2003).</p> <p>Information and personal data gathered from service users/clients is done so with the following criteria:</p> <ul style="list-style-type: none">• Clarity of purpose• Clarity of access• Used appropriately• Necessary data collected only• Processed fairly• Stored safely and securely | | | | | |

Step 2: Foundation Level

| | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Services – Programmes – Practices | | | | | | |
| Indicator: Recording Information | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| Records held by the organisation are factual, consistent and accurate. | | | | | | |
| Record held by the organisation contain relevant information and pertinent details about client services. | | | | | | |
| Records of client services/contact are up to date, signed and dated. | | | | | | |
| Service users/clients can access and view their record of contact subject to the Freedom of Information act (1997/2003). | | | | | | |
| Records of contact are stored in a secure place, and there is no unauthorised access, alteration or destruction of data. | | | | | | |

Step 2: Foundation Level

| | | | | | |
|--|--|-------------------------------|--------------|----------------------|----------------|
| Theme: Services – Programmes – Practices | | | | | |
| Indicator: Communication | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | Not Applicable |
| <p>The organisation provides guidance to staff on addressing and responding to issues ethically and in a professional manner at all times.</p> <p>The organisation is open and clear in all communication both written and oral.</p> <p>The organisation uses different formats to communicate information in a meaningful way.</p> <p>Staff and volunteers are kept informed of new developments and changes in the sector/organisation.</p> <p>The organisation uses language that is clear and uses plain language.</p> | | | | | |

Step 2: Foundation Level

| | | | | | | |
|--|--|-------------------------------|--------------|----------------------|-----------|----------------|
| Theme: Technology | | | | | | |
| Indicator: Information | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| <p>The information and/or research placed on the website is reputable and accurately sourced.</p> <p>Internet and web based information used by/placed by the organisation is chosen from reliable and high quality sources/national recognised sources.</p> <p>The website of the organisation is clear and simple.</p> | | | | | | |

Step 2: Foundation Level

| | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Technology | | | | | | |
| Indicator: Data Security | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| Personal data held by the organisation is stored securely and either password protected and/or encrypted. | | | | | | |
| Electronic data and files are maintained by the organisations using the following guidelines: | | | | | | |
| <ul style="list-style-type: none">• Awareness of client confidentiality• Log of when work is finished• Avoid accidental viewing - Do not leave computers/laptops unattended• Logins are not shared with other people• Passwords changed regularly• Records are private and not accessible to general public | | | | | | |
| The organisation uses legitimate and licensed software. | | | | | | |

Step 2: Foundation Level

| | | | | | | |
|---|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Technology | | | | | | |
| Indicator: Policy | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| <p>The organisation has a clear policy and procedure for use of internet and email by employees and others with access.</p> <p>The organisation has clear policy and procedure in relation to the management and removal of illegal content. (see Internet Watch Foundation).</p> <p>The organisation ensures the vetting of any staff/volunteers with access to vulnerable clients within an online service to protect and safeguard the individual.</p> <p>An effective reporting mechanism for any inappropriate or unwanted communication exists within the organisation and between them and law enforcement bodies.</p> <p>Provide clear training as to expected good conduct and appropriate use of language and behaviour in an online service or forum.</p> | | | | | | |

Step 2: Foundation Level

| | | | | | |
|--------------------------------------|--|------------------------|--------------|----------------------|-----------|
| Theme: Technology | | | | | |
| Indicator: Risk, Consent and Privacy | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | |
| | <p>The organisation has a defined and determined understanding of low, medium and high risk behaviour with an appropriate response matrix in order to mitigate and respond to risk (for example refer to Risk Awareness and Management Programme).</p> <p>To ensure valid engagement the organisation requires that the consent given is valid and freely given by one who has the mental capacity to do so. This ensures adherence to legal requirements.</p> <p>The organisation ensures as far as practicable that the consent is, competent, of legal age and in position to permit the processing of personal data by the online service.</p> <p>The organisation protects the privacy of service users on line with procedures to ensure client personal profiles are not, "searchable".</p> <p>The organisation ensures that the sharing of content online is enshrined within an effective confidentiality mechanism adhered to by staff/volunteers and online participants.</p> | | | | |

Step 2: Foundation Level

| Theme: Technology | | | | | | |
|-----------------------|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Moderation | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | <p>The organisations is aware and ensure that their online service is regularly assessed and moderated for potential risk to children, vulnerable adults and service users.</p> <p>Moderation as an affirming process is an integral practice within the organisations processes ensuring and encourage a safe practice and engagement within their online service.</p> <p>The organisation makes use of either effective filtering software or human moderators in reviewing and assessing potential risk to children, vulnerable adults and service users which permit the removal of content deemed to be inappropriate or the restriction of use by anyone deemed to be questionable in their usage of the service.</p> <p>The organisation ensures a consistent policy across their virtual domain whether website, Twitter feed, Social Network page, Video conferencing capacity or blog.</p> | | | | | |

Step 2: Foundation Level

| | | | | | | |
|-------------------------------------|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Knowledge/ Training/Research | | | | | | |
| Indicator: Training | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation ensures staff and volunteers have access to training and development courses and facilitate to attendance.</p> <p>The organisation ensures staff and volunteers have received training in suicide awareness and suicide prevention/intervention.</p> <p>The organisation plans and/or delivers induction training.</p> <p>Training is provided for staff, volunteers and committee members on governance, policies and procedures.</p> <p>The organisation ensures that staff/volunteers understand the boundaries of their role, continuous professional development.</p> | | | | | |

Step 2: Foundation Level

| | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Knowledge/ Training/Research | | | | | |
| Indicator: Qualifications | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| | | | | | |
| The organisation ensures that staff and volunteers have appropriate qualifications and skills for their assigned role. | | | | | |

8.4 STEP 3: Prevention, Education and Support Level

The **STEP** model seeks to ensure that through good governance and effective management at a foundation and universal level that organisations are best placed to deliver coordinated practices and services of consistently high quality, with education a particular and important aspect to overall provision within the sphere of suicide Pre/Inter/Postvention practice. Coupled with this any information transmitted must also be delivered within a clear and concise framework and in a practical and understandable language and manner. The organisation is accountable to ensure effective governance around the responsible, considered practice and strategy in the development of effective services.

In addition to the Foundation Level, Step 3 comprises core activities that organisations undertake. These activities involve **Prevention, Education and Support** and a number of distinct indicators, listed below will assist organisations to ensure required standards of practice.

Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Purpose | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation has a clear defined purpose for its services in the following spheres:</p> <ul style="list-style-type: none">• Support Services• Mental Health Promotion• Prevention Activities• Education• Postvention• Complimentary/Alternative therapies | | | | | |

Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Support Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Support Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation promotes and supports positive communal connections in highlighting the value of the individual.</p> <p>Services are developed in tandem with identified need.</p> <p>The organisation signposts alternative agencies if they cannot meet the support need.</p> <p>Staff/volunteers are aware of their practice limitation in offering support and will refer on to more effective and pertinent services.</p> | | | | | |

Step3: Prevention, Education and Support Level

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|---|--|------------------------|--------------|----------------------|-----------|
| Theme: Prevention, Education and Support Level | | | | | |
| Indicator: Mental Health Promotion | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| The organisation adheres to a positive mental health promotion agenda. | | | | | |
| The organisation has an innovative approach to mental health promotion. | | | | | |
| The organisation offers a range of mental health promotion activities/services, for example: | | | | | |
| <ul style="list-style-type: none">• Media campaigns• Information and awareness raising | | | | | |
| The mental health promotion information is current, concise and clear. | | | | | |
| The organisation evaluates and develops mental health promotion resources in tandem with identified need. | | | | | |
| Staff/volunteers are aware of their practice limitation in offering mental health promotion activities. | | | | | |

Step3: Prevention, Education and Support Level

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|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Prevention, Education and Support Level | | | | | | |
| Indicator: Prevention | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | <p>The organisation offers a range of prevention services, for example:</p> <ul style="list-style-type: none">• Information and Awareness• Media Campaigns• Schools and Community initiatives <p>The prevention information is current, concise and clear.</p> <p>The organisations prevention services are mindful, sensitive and respectful around values, beliefs and cultural practices.</p> | | | | | |

Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Prevention | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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| | <p>The prevention services are offered locally, regionally and/or nationally.</p> <p>The prevention services/needs of client/s, the families and communities are assessed and identified.</p> <p>Prevention Services are developed in tandem with identified need.</p> <p>The prevention services/initiatives are planned strategically and in consultation with key stakeholders.</p> <p>Staff/volunteers are aware of their practice limitation in offering prevention support.</p> | | | | | |

Step3: Prevention, Education and Support Level

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|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Prevention, Education and Support Level | | | | | | |
| Indicator: Education Programmes | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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Step3: Prevention, Education and Support Level

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|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Prevention, Education and Support Level | | | | | |
| Indicator: Education Programmes | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| | <p>Delivery of programmes and materials takes into consideration differing ability whether physical or other in terms of accessibility to and understanding of programmes and material.</p> <p>Programmes and material provided are presented in a number of languages.</p> <p>Programmes and material are supportive and welcoming.</p> <p>Programmes and material are informed by client/community/staff involvement and experience.</p> <p>Programmes and material continually assessed and developed where necessary.</p> <p>Cooperation between local and national bodies informs and influences the material and content and its delivery.</p> | | | | |

Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | |
|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Postvention | | | | | |
| Elements: | Self-Assessment Status | | | | |
| | Not met | Just started | Making good progress | Fully met | Not Applicable |
| The organisation offers a range of postvention services, for example: <ul style="list-style-type: none">• Listening ear/telephone support• Support group• Family support The postvention information is current, concise and clear. The organisations postvention services are mindful, sensitive and respectful around values, beliefs and cultural practices. | | | | | |

Step3: Prevention, Education and Support Level

| Theme: Prevention, Education and Support Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Postvention | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The postvention services are offered locally, regionally and/or nationally.</p> <p>The postvention services/needs of client/s, the families and communities are assessed and identified.</p> <p>Postvention Services are developed in tandem with identified need.</p> <p>The organisation signposts to appropriate and alternative agencies if they cannot meet the postvention support need.</p> <p>Staff/volunteers are aware of their practice limitation in offering postvention support.</p> | | | | | |

8.5 Step Four: Intervention, Targeted and Specialist Level

The STEP model aims to ensure that through good governance and effective management at a foundation level that organisations are best placed to deliver coordinated practices and services of consistently high quality within the sphere of suicide Pre/Inter/Postvention practice. Coupled with this any information transmitted must also be delivered within a clear and concise framework and in a practical and understandable language and manner.

In addition to the Foundation Level, Step 4 comprises core activities that organisations undertake. These activities involve intervention, targeted and specialist services and a number of distinct indicators, listed below will assist organisations to ensure required standards of practice.

Step 4: Intervention, Targeted and Specialist Level

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|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Intervention, Targeted and Specialist Level | | | | | |
| Indicator: Intervention and Targeted Services | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| | | | | | |
| | <p>The organisation offers a range of intervention services, for example:</p> <ul style="list-style-type: none">• Individual Counselling Services• Bereavement counselling services• Group therapeutic programmes• Critical Incident management/protocols• Postvention programmes/services | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Intervention and Targeted Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | | | | | | |
| | <p>The organisation offers a range of intervention services, for example:</p> <ul style="list-style-type: none">• Individual Counselling Services• Bereavement counselling services• Group therapeutic programmes• Critical Incident management/protocols• Postvention programmes/services | | | | | |

Step 4: Intervention, Targeted and Specialist Level

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|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Intervention, Targeted and Specialist Level | | | | | |
| Indicator: Intervention and Targeted Services | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
| The intervention information used by the organisation is current, concise and clear. | | | | | |
| The organisation ensures that practicing counsellors/therapists working through the organisation have valid and current qualification pertinent to their practice. | | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Intervention and Targeted Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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| | <p>The organisation ensures that practicing counsellors/therapists working through the organisation, have valid and current accreditation (are working toward accreditation) to a recognised national body.</p> <p>Counsellor and therapists working in the organisation adhere to the ethical and professional code of conduct of the recognised accrediting body.</p> <p>The organisations intervention services are mindful, sensitive and respectful around values, beliefs and cultural practices.</p> <p>The intervention services are offered locally, regionally and/or nationally.</p> | | | | | |

Step 4: Intervention, Targeted and Specialist Level

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|---|--|------------------------|--------------|----------------------|-----------|
| Theme: Intervention, Targeted and Specialist Level | | | | | |
| Indicator: Intervention and Targeted Services | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| The intervention services/needs of client/s, the families and communities are assessed and identified using appropriate assessment tools/methods. | | | | | |
| Intervention Services are developed in tandem with assessed/identified need. | | | | | |
| The intervention services/initiatives are planned strategically and in consultation with key stakeholders. | | | | | |
| Counsellor/therapists are aware of their practice limitation in offering intervention services and support. | | | | | |
| The organisation ensures continuous professional development and appropriate training for all counsellors / therapists. | | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Intervention and Targeted Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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| | <p>Staff and volunteers have regular and on-going supervision in accordance with service and accrediting body requirements.</p> <p>If assessment indicates high risk requiring acute medical/psychiatric service interventions referral protocols are implemented and followed.</p> <p>The organisation follows a strict risk management policy and procedure to ensure the safeguarding of staff/volunteers and vulnerable clients.</p> <p>The organisation ensures that it articulates to clients agreed limits to any confidentiality process where it becomes clear there is a real and present danger to the wellbeing of the client or to others.</p> | | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Education programmes | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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| | <p>The organisation ensures that staff and volunteers are suitably qualified to perform and carry out any specialist and targeted intervention programmes.</p> <p>That a minimum standard of acceptable qualification be agreed upon and regularly revisited and reviewed in light of practice.</p> <p>That the programmes be developed in partnership with the local communities and interested stakeholders to ensure viability and appropriate content.</p> <p>Programmes and material take into account cultural and ethnic differences.</p> | | | | | |

Step 4: Intervention, Targeted and Specialist Level

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|--|--|------------------------|--------------|----------------------|-----------|
| Theme: Intervention, Targeted and Specialist Level | | | | | |
| Indicator: Education programmes | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| Delivery of programmes and materials takes into consideration differing ability whether physical or other in terms of accessibility to and understanding of programmes and material. | | | | | |
| Programmes and material provided are presented in a number of languages. | | | | | |
| Programmes and material are supportive and welcoming. | | | | | |
| Programmes and material are informed by client/community/staff involvement and experience. | | | | | |

Step 4: Intervention, Targeted and Specialist Level

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|---|--|------------------------|--------------|----------------------|-----------|
| Theme: Intervention, Targeted and Specialist Level | | | | | |
| Indicator: Education programmes | | | | | |
| Elements: | | Self-Assessment Status | | | |
| | | Not met | Just started | Making good progress | Fully met |
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| <p>Programmes and material continually assessed and developed where necessary.</p> <p>Cooperation between local and national bodies informs and influences the material and content and its delivery.</p> <p>The organisation insists that specialist targeted intervention programmes ensure the safety and wellbeing of vulnerable clients and service users.</p> <p>The organisation pursues and engages in authentic research and development pertinent to and supporting and informing best quality of practice within the spheres of Pre/Inter and Postvention.</p> | | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|---|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Postvention Services | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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| | <p>The organisation offers a range of postvention services, for example:</p> <ul style="list-style-type: none">• Individual Counselling Services• Bereavement counselling services• Group therapeutic programmes• Critical Incident management/protocols• Postvention programmes/services | | | | | |

Step 4: Intervention, Targeted and Specialist Level

| Theme: Intervention, Targeted and Specialist Level | | | | | | |
|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Indicator: Postvention | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
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Step 4: Intervention, Targeted and Specialist Level

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|--|--|------------------------|--------------|----------------------|-----------|----------------|
| Theme: Intervention, Targeted and Specialist Level | | | | | | |
| Indicator: Postvention | | | | | | |
| Elements: | | Self-Assessment Status | | | | |
| | | Not met | Just started | Making good progress | Fully met | Not Applicable |
| | <p>The postvention services/needs of client/s, the families and communities are assessed and identified.</p> <p>Postvention Services are developed in tandem with identified need.</p> <p>The organisation signposts to appropriate and alternative agencies if they cannot meet the postvention support need.</p> <p>Staff/volunteers are aware of their practice limitation in offering postvention support.</p> | | | | | |

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